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FAST FACTS

- Eligible employees generally have three options for medical coverage and three options for dental coverage; voluntary vision coverage is also available for purchase;
- JHU automatically provides life insurance, accidental death & dismemberment (AD&D) and business travel accident insurance to eligible employees; eligible employees may elect to purchase additional coverage. JHU automatically provides long-term disability benefits to eligible employees; eligible employees may elect to purchase short-term disability coverage;
- JHU’s Faculty and Staff Assistance Program provides employees and their families with assistance around personal, relationship, and financial issues; and
- With the flexible spending accounts, eligible employees can use before-tax dollars to pay for covered health care and dependent care expenses.

If you are an eligible JHU employee, you receive a wide array of benefits that give you and your family important protection, security and peace of mind. The following benefits are available as described in this Health and Welfare Handbook:

- Medical — three options, each of which includes prescription drug coverage
  
  For full-time and part-time faculty and staff:
  - An indemnity plan – CareFirst BlueCross BlueShield Medical
  - A dual option, point-of-service (POS) plan – EHP Classic Plan
  - Two health maintenance organizations (HMO) – BlueChoice HMO (closed to new participants) or Kaiser Permanente HMO
  
  For full-time and part-time bargaining unit employees:
  - An indemnity plan – CareFirst BlueCross BlueShield Medical
  - Two health maintenance organizations (HMOs) – BlueChoice HMO or Kaiser Permanente HMO
  
  For limited-time employees:
  - An indemnity plan – CareFirst BlueCross BlueShield Plan III

- Dental — three options
  
  - Two preferred provider organization (PPO) plans
  - A dental health maintenance organization (DMO)

- Life, AD&D insurance, and business travel accident insurance
  
  - Basic life insurance
  - Supplemental life insurance
  - AD&D (faculty and staff only)
  - Business travel accident insurance
  - Dependent life insurance

- Disability protection
  
  - Short-term disability
  - Long-term disability
• Family Leave
  - Birth recovery leave
  - Parental leave
• Flexible spending accounts
  – Health care flexible spending account
  – Dependent care flexible spending account
• Faculty and Staff Assistance Program
• Healthy at Hopkins Wellness Program
• Voluntary benefits:
  – Accident insurance
  – Auto insurance
  – Critical illness insurance
  – Homeowner’s insurance
  – Legal Insurance
  – Travel Assistance and Identity Theft Protection
  – Vision plan

**Health and Welfare Benefits-At-A-Glance**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Faculty and Staff</td>
</tr>
</tbody>
</table>
| **Medical** | • Broad medical coverage, including preventive care and prescription drug coverage  

• Choice of three medical options:  
  – An indemnity plan – CareFirst BlueCross BlueShield Medical  
  – A dual option, point-of-service (POS) plan – EHP Classic Plan  
  – A health maintenance organization plan (HMO)  
    (i) Kaiser Permanente HMO or  
    (ii) BlueChoice HMO [closed to new participants]  
  – An indemnity plan – CareFirst BlueCross BlueShield Plan III [for limited-time employees only] | • Broad medical coverage, including preventive care and prescription drug coverage  

• Choice of three medical options:  
  – An indemnity plan – CareFirst BlueCross BlueShield Medical  
  – Two health maintenance organizations (HMOs) – BlueChoice HMO or Kaiser Permanente HMO  
  – An indemnity plan – CareFirst BlueCross BlueShield Plan III [for limited-time employees only] |
<p>| <strong>Dental</strong> | Three choices of coverage for many preventive, diagnostic, and other treatments, including orthodontia. | Three choices of coverage for many preventive, diagnostic, and other treatments, including orthodontia. |</p>
<table>
<thead>
<tr>
<th>Plan</th>
<th>Faculty and Staff</th>
<th>Bargaining Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Voluntary Vision</strong></td>
<td>Optional vision coverage providing eye exams, as well as discounts on glasses and contact lenses.</td>
<td>Optional vision coverage providing eye exams, as well as discounts on glasses and contact lenses.</td>
</tr>
<tr>
<td><strong>Life Insurance</strong></td>
<td>JHU provides $10,000 of coverage at no cost to eligible employees.</td>
<td>JHU provides coverage of 100% of base salary at no cost to eligible employees.</td>
</tr>
<tr>
<td></td>
<td>Opportunity to elect additional coverage to a total of $50,000 or 150%, 250%, or 400% of your base annual salary up to a maximum total (combined with the JHU-provided coverage) of $2,000,000 (if you select additional coverage, you pay the cost of that coverage and a Statement of Health may be required).</td>
<td>Opportunity to elect additional coverage equal to one times your base annual salary (if you select additional coverage, you pay the cost of that coverage and a Statement of Health may be required).</td>
</tr>
<tr>
<td><strong>Accidental Death &amp; Dismemberment (AD&amp;D)</strong></td>
<td>JHU provides $10,000 coverage at no cost to eligible employees.</td>
<td>AD&amp;D is not available to bargaining unit employees.</td>
</tr>
<tr>
<td></td>
<td>Opportunity to elect additional coverage for eligible employees and certain family members up to 400% of base salary (eligible employees who select additional coverage pay the cost of that coverage).</td>
<td></td>
</tr>
<tr>
<td><strong>Business Travel Accident Insurance</strong></td>
<td>JHU provides $200,000 of coverage at no cost to eligible employees.</td>
<td>JHU provides $50,000 of coverage at no cost to eligible employees.</td>
</tr>
<tr>
<td><strong>Critical Illness Insurance</strong></td>
<td>Opportunity for eligible employees to elect financial protection during treatment for illnesses such as cancer and Alzheimer’s disease. Three options for coverage: $10,000, $15,000, $20,000</td>
<td>Opportunity for eligible employees to elect financial protection during treatment for illnesses such as cancer and Alzheimer’s disease. Three options for coverage: $10,000, $15,000, $20,000</td>
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<tr>
<td>Plan</td>
<td>Coverage</td>
<td>Bargaining Unit</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Accident Insurance</strong></td>
<td>Ability to purchase low-cost coverage that pays benefits if involved in an accident off the job.</td>
<td>Ability to purchase low-cost coverage that pays benefits if involved in an accident off the job.</td>
</tr>
</tbody>
</table>
| **Dependent Life Insurance** | Opportunity for eligible employees to elect one of two coverage options:  
- $4,000 for spouse/domestic partner and $2,000 per child; or  
- $10,000 for spouse/domestic partner and $5,000 per child. | JHU provides $4,000 for spouse/domestic partner and $2,000 per child at no cost to eligible employees.                                                                                                       |
<p>| <strong>Family Leave</strong>             | Mothers who give birth and meet the eligibility requirements are entitled to six weeks of fully paid birth recovery leave following the birth of a child. Four weeks paid parental leave is available to eligible parents, including adoptive parents of children under age 12 and parents of children born via surrogate within 12 months following birth or place of child. | Mothers who give birth and meet the eligibility requirements are entitled to six weeks of fully paid birth recovery leave following the birth of a child. Four weeks paid parental leave is available to eligible parents, including adoptive parents of children under age 12 and parents of children born via surrogate within 12 months following birth or place of child. |
| <strong>Short-Term Disability (STD)</strong> | Opportunity for eligible employees to elect coverage that pays 60% of pre-disability weekly earnings (with benefits not to exceed $2,500 a week) for up to 11 weeks, if the eligible employee is unable to work more than 14 consecutive days and the claim has been approved (eligible employees who select this coverage pay the cost of the coverage). | Opportunity for eligible employees to elect coverage that pays 60% of pre-disability weekly earnings (with benefits not to exceed $2,500 a week) for up to 11 weeks, if the eligible employee is unable to work more than 14 consecutive days and the claim has been approved (eligible employees who select this coverage pay the cost of the coverage). |</p>
<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage</th>
<th>Bargaining Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Long-Term Disability (LTD)</strong></td>
<td>JHU provides coverage if an illness or injury continues past 90 days and results in an eligible employee’s disability as defined by the plan, the plan generally provides 60% of pre-disability base salary, up to a maximum monthly benefit of $10,000, during the extended disability or until age 65, whichever occurs first.*</td>
<td>JHU provides coverage if an illness or injury continues past 90 days and results in an eligible employee’s disability as defined by the plan, the plan generally provides 60% of pre-disability base salary, up to a maximum monthly benefit of $10,000, during the extended disability or until age 65, whichever occurs first.*</td>
</tr>
<tr>
<td><strong>Flexible Spending Accounts</strong></td>
<td>Eligible employees may contribute to a health care flexible spending account up to $2,600 a year on a before-tax basis to pay for eligible health care expenses. Up to $500 in unused health care FSA contributions will automatically be carried over to the next calendar year and can be applied to eligible expenses in that year. Eligible employees may contribute up to $5,000 a year on a before-tax basis to pay for eligible dependent care expenses ($2,500 if married and filing a separate tax return).</td>
<td>Eligible employees may contribute up to $2,600 a year on a before-tax basis to pay for eligible health care expenses. Up to $500 in unused health care FSA contributions will automatically be carried over to the next calendar year and can be applied to eligible expenses in that year. Eligible employees may contribute up to $5,000 a year on a before-tax basis to pay for eligible dependent care expenses ($2,500 if married and filing a separate tax return).</td>
</tr>
<tr>
<td><strong>Faculty and Staff Assistance Program</strong></td>
<td>Assistance with personal, relationship, and financial issues.</td>
<td>Assistance with personal, relationship, and financial issues.</td>
</tr>
<tr>
<td><strong>Work/Life Program</strong></td>
<td>A variety of programs available to assist in finding balance in your personal and professional life. Programs offer support for adoption, dependent/elder care, housing and professional counseling.</td>
<td>A variety of programs available to assist in finding balance in your personal and professional life. Programs offer support for adoption, dependent/elder care, housing and professional counseling.</td>
</tr>
<tr>
<td><strong>Wellness Program</strong></td>
<td>A wide array of wellness activities and services available as part of Healthy at Hopkins.</td>
<td>A wide array of wellness activities and services available as part of Healthy at Hopkins.</td>
</tr>
</tbody>
</table>
Plan Coverage

Faculty and Staff
- An opportunity to purchase a variety of supplemental insurance coverages at group rates through payroll deduction:
  - Auto insurance
  - Homeowner’s insurance
  - Legal Insurance
  - Travel Assistance and Identity Theft Protection

Bargaining Unit
- An opportunity to purchase a variety of supplemental insurance coverages at group rates through payroll deduction:
  - Auto insurance
  - Homeowner’s insurance
  - Legal Insurance
  - Travel Assistance and Identity Theft Protection

* Eligible employees are those who have completed one year of employment or, those employed by JHU within three months of leaving another employer, where they were covered under a similar plan for at least one year.

Eligibility and Participation

Eligibility for Employees

The following chart summarizes the eligibility rules for the JHU health and welfare benefit plans, based on your employment status. *(Please note that some plans are voluntary and require eligible employees to make an election and pay the cost of the benefit.)*

<table>
<thead>
<tr>
<th>Status</th>
<th>Health and Welfare Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full-Time</strong></td>
<td>- Medical plans&lt;br&gt;- Dental plans&lt;br&gt;- Voluntary Vision plan&lt;br&gt;- Life Insurance&lt;br&gt;- AD&amp;D (faculty and staff only)&lt;br&gt;- Business Travel Accident Insurance&lt;br&gt;- Disability Insurance&lt;br&gt;- Family Leave&lt;br&gt;- Flexible Spending Accounts&lt;br&gt;- Voluntary Benefits</td>
</tr>
<tr>
<td>Faculty/Staff: 28 or more hours per week&lt;br&gt;Bargaining Unit: 30 or more hours per week</td>
<td></td>
</tr>
<tr>
<td><strong>Part-Time</strong></td>
<td>- Medical plans&lt;br&gt;- Family Leave&lt;br&gt;- Life Insurance (Bargaining Unit Only)</td>
</tr>
<tr>
<td>Faculty/Staff: 19-27 hours per week&lt;br&gt;Bargaining Unit: 20 or more hours per week</td>
<td></td>
</tr>
</tbody>
</table>
**Status** | **Health and Welfare Benefits**
---|---
**Limited-Time**<br>28 or more hours per week for a maximum of 6 months (12 months if schedule is intermittent) | -Medical plan

**Visiting Full-Time Faculty*** | -Medical plans
- Life Insurance

*Note: Visiting part-time faculty members are eligible for the medical plans only.

Except as noted above for long-term disability insurance, the applicable Eligibility Date is the first day of employment in an eligible status, whether the employee joins as a new hire in that status or experiences a change in status.

**Eligibility for Dependents**

Eligible employees may also cover eligible dependents under the medical, dental, dependent life and AD&D insurance plans, as follows:

- Their legally married spouse or domestic partner;* and
- Their child(ren) up until the end of the year in which the child turns age 26. Coverage may be continued for children up to any age, if they cannot support themselves because of a mental or physical disability (certification of disability is required) that occurred before the end of the year in which the child turns age 26.

* Must qualify for coverage under the JHU Domestic Partner Benefits Policy, described below.

For this purpose, “children” are: biological children, adopted children, children placed with the eligible employee for adoption, stepchildren, children of the employee’s domestic partner or children for whom the eligible employee has been appointed legal guardian.

This “Eligibility of Dependents” section does not apply to flexible spending accounts benefits. For details on whether a family member’s expenses can be covered under a health care flexible spending account or a dependent care flexible spending account, see the separate explanations of those benefits later in this document.

**Coverage Levels**

When you enroll, you choose your coverage level for medical and dental. Dependents may be covered only under the coverage level you elect for yourself. The available coverage levels are:

- Individual: This includes faculty, staff or bargaining unit employee.
- Adult and child(ren): This includes faculty, staff or bargaining unit employee and one or more children.
- 2 adults: This includes faculty, staff or bargaining unit employee and spouse or domestic partner.*
- 2 adults and child(ren): This includes faculty, staff or bargaining unit employee, spouse or domestic partner* and one or more children.

* Must qualify for coverage under the JHU Domestic Partner Benefits Policy, described below.

**Domestic Partner Benefits Policy**

JHU medical, dental, AD&D and dependent life insurance benefits are extended to domestic partners of eligible employees and those domestic partners’ children, provided the children qualify for coverage under
the dependent children definition above. To apply for benefits for your domestic partner and your domestic partner’s children, you and your domestic partner must complete the JHU Affidavit of Marriage/ Domestic Partnership form. This form should be completed with your benefit elections. If your domestic partnership ends, you must complete and submit the JHU Termination Statement of Marriage/ Domestic Partnership form within 30 days after the termination of your relationship.

These forms (JHU Affidavit of Marriage/ Domestic Partnership form and JHU Termination Statement of Marriage/ Domestic Partnership form) must be submitted to the Benefits Service Center.

**Tax Treatment of Domestic Partner Benefits**

Under federal law, domestic partners are not recognized as spouses. So, if your domestic partner or any child of your domestic partner does not qualify as your dependent for federal income tax purposes (under special rules that apply for purposes of employer-sponsored health benefits), the Internal Revenue Code requires that the fair market value of any JHU-paid health benefits provided for that person must be treated as taxable income to you.

Your domestic partner or a child of a domestic partner generally will qualify as your dependent for federal income tax purposes only if he or she shares the same principal residence as you for the applicable calendar year and you provide more than half of his/ her support for the calendar year.

JHU will treat the value of coverage provided to a non-dependent domestic partner or child as taxable income to you and will withhold taxes on that imputed income. In addition, any contributions you make to purchase benefits for a non-dependent domestic partner or child must be made with after-tax dollars. If you believe your domestic partner or any child of your domestic partner is your federal income tax dependent for purposes of health benefits, you may certify their dependent status by signing a Tax Dependent Certification form and submitting it to the Benefits Service Center. JHU will not treat coverage provided to a domestic partner or child as taxable if you do not properly certify that person’s tax dependent status. If you do not complete a Tax Dependent Certification for an applicable calendar year for your domestic partner or a child of a domestic partner, JHU will treat any health coverage for that domestic partner or child as a taxable benefit.

*Please note: Under federal tax law, neither the dependent care flexible spending account nor the health care flexible spending account may be used for expenses of domestic partners or their children unless they qualify as your eligible dependent under the specific federal tax law definitions that apply to dependent care and health care flexible spending accounts.*

**The myChoices Program – A Flexible Benefits Approach**

Recognizing that each of us has different needs, JHU offers the myChoices Program, which is a flexible approach to benefits. Under this approach, JHU provides a number of benefits automatically to eligible employees, and then eligible employees decide which additional benefits they wish to purchase to meet their needs.

In the table below, “JHU-Paid Benefits” are those benefits that are automatically given to an eligible employee and paid for by JHU. The additional benefits elected by an eligible employee are called “Your Benefit Elections.”
<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>JHU-Paid Benefits</th>
<th>Your Benefit Elections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Coverage</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Dental Coverage</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Voluntary Vision Coverage</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Supplemental Life Insurance</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>AD&amp;D (Basic and Supplemental, Faculty and Staff only)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Family Leave</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Business Travel Accident Insurance</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Critical Illness Insurance</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Accident Insurance</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Dependent Life Insurance (Bargaining Unit only)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Dependent Life Insurance (Faculty and Staff only)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Short-Term Disability</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Long-Term Disability</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Health Care Spending Account</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Dependent Care Spending Account</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Voluntary Benefits</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**How to Enroll**

**New Hires**

When you begin employment as an eligible employee, you will receive information from the Benefits Service Center (BSC) about the myChoices Program and enrollment instructions. The enrollment information from the BSC will include your deadline to enroll for benefits: **30 days from the notification date**.

Full time faculty, staff and bargaining unit members are also eligible to participate in the university’s voluntary benefit programs which include Auto/Homeowner’s Insurance, Legal Insurance, and Accident Insurance. Plan details can be found on the Johns Hopkins University Voluntary Benefits website at [www.jhuvoluntarybenefits.com](http://www.jhuvoluntarybenefits.com).
Faculty and Staff Default Enrollment

If you do not enroll by the deadline, you will automatically be enrolled in default medical coverage consisting of an individual (employee only) dual-option point of service medical plan (EHP Classic Plan). The effective date of your coverage will be retroactive to your first date of eligibility. You will also receive JHU-paid benefits such as $10,000 in basic life insurance coverage and $10,000 in AD&D Insurance.

Bargaining Unit Default Enrollment

If you do not enroll by the deadline, you will receive JHU-paid basic life insurance and dependent life insurance coverage.

You will not be enrolled in any of the other myChoices Program options, including the flexible spending accounts (FSAs). Your next opportunity to make changes will be during the next annual enrollment period, unless you experience a qualifying event (e.g., a change in family status, a special enrollment event, or a qualifying change in cost or coverage).

Whether you enroll before the deadline or are assigned default coverage, the effective date of your coverage is retroactive to your first date of eligibility. There is an exception for long-term disability benefits as explained below.

Annual Enrollment

In the fall of each year, during the annual enrollment period, you will be given an opportunity to select benefits for which you are eligible for the following calendar year. All annual enrollment elections become effective on January 1 of the following year.

If you do not elect to change your coverage during the annual enrollment period, your elections for the previous year (excluding your participation in the FSAs) will automatically be continued for the next calendar year (assuming continued eligibility). Mid-year changes are limited to those permitted as the result of a qualifying event.

When Coverage Begins

An eligible employee’s coverage for benefits selected in the myChoices Program generally starts on the first day of employment in an eligible status. However, there is an exception for long-term disability (LTD) benefits. Coverage for LTD will generally begin after 12 months of full-time continuous employment and on the first day of the month following completion of this 12-month waiting period. The 12-month waiting period may be waived for those employees who are hired by JHU within three months after being covered under the long-term disability plan of a previous employer, and who were covered under that plan for at least one year. Proof of prior coverage is required in order to waive the 12-month waiting period.

Also, if you are not actively at work on the date your life insurance and AD&D insurance would take effect, or the date a change to your supplemental life insurance and additional AD&D would take effect, these benefits will not take effect until you return to work for one full day. Your benefit elections generally become effective on the effective date shown on your Benefits Confirmation Statement.

Benefits elected during annual enrollment become effective January 1 of the following year or in the case of supplemental life insurance, the date that any required evidence of insurability is approved. With the exception of certain special enrollment rights under the medical plan options, mid-year election changes permitted under the flexible benefits program as a result of a qualifying event generally become effective as soon as administratively reasonable after receipt of the election form.
How Long Coverage Lasts & Changing Your Elections

Each fall, during the annual enrollment period, you will have the opportunity to change your benefits for the next calendar year. Once made, these elections generally cannot be changed and will remain in effect from January 1 through December 31 of the following year. However, you may be permitted to change your benefit elections during the year (and outside of the annual enrollment period) under certain limited circumstances described in this document under the headings, “Qualifying Events,” “Changes in Family Status,” “Special Enrollment Events,” “Change in Cost or Coverage” and “Other Qualifying Events.”

As described earlier, if you do not change your elections during the annual enrollment period, your elections (except for FSA elections, which expire at the end of each calendar year) will carry over to the next year.

Qualifying Events

You may change your benefit elections if you experience a qualifying event in one of the categories described below. To make changes, please contact the Benefits Service Center. Changes must be elected within 30 days of the qualifying event and the 30-day period begins as of the date of the event. Otherwise, you will not be able to change your benefits until the next annual enrollment period. Elections made during annual enrollment become effective January 1 of the following year. You may be asked to submit additional forms related to your qualifying event, depending on the benefits being changed. Coverage changes are processed within a reasonable period of time after you make your election change, with the exception of medical coverage for a birth or adoption, when coverage is applied retroactively to the date of the event.

Qualifying events include certain changes in status, special enrollment events, certain changes in cost or coverage and certain miscellaneous events as described below.

Changes in Status

The following changes in status are qualifying events:

- A change in legal marital status (marriage, divorce, legal separation, annulment or death of a spouse);
- A change in the number of dependents as a result of birth, adoption, change in guardianship, death, and establishment or dissolution of a domestic partnership;
- A change in employment status for you, your spouse, domestic partner or dependent (such as termination or commencement of employment; commencement of or return from an unpaid leave of absence);
- A change in place of residence or employment for you, your spouse, domestic partner or dependent;
- A change in eligibility for coverage as a result of a judgment, decree or order (including a Qualified Medical Child Support Order); or
- Any event that causes a dependent to satisfy or cease to satisfy the requirements for coverage as specified in the plan(s).

You can make a new election in response to one of these qualifying events only if the election is on account of and consistent with the event. An election change must be on account of a qualifying event that affects eligibility under an employer’s plan, including an increase or decrease in the number of dependents who may be covered under the plan. For example, in the case of marriage, birth, adoption or placement for adoption, you can change your medical coverage category to “2 adults + child(ren)” coverage. If you, your spouse, domestic partner, or dependent gains eligibility for coverage under another plan due to a status change event, you may cease or decrease coverage under JHU’s flexible benefit plan only upon certification of new or increased coverage under the spouse’s, domestic partner’s or dependent’s plan.
In addition, upon your divorce, legal separation or annulment, the death of your spouse, domestic partner or a dependent, or a dependent ceasing to be eligible under the JHU flexible benefit plan, you generally may not cancel coverage under a health care option for any individual other than the affected spouse, domestic partner or dependent. Also, upon any change in status that affects eligibility under any employer’s plan, you may elect to either increase or decrease your coverage under a life insurance option, subject to any evidence of insurability requirements.

**Special Enrollment Events**

If you decline enrollment in the Plan’s health coverage options for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan’s health coverage features if you or your dependents lose eligibility for that other coverage (or if an employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after you or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the Plan’s health coverage. However, you must request enrollment within 30 days after the marriage, establishment of domestic partnership, birth, adoption, or placement for adoption.

If you or your eligible dependent are covered under Medicaid or a State Children’s Health Insurance Program (CHIP) and that coverage ends, you may be able to enroll yourself and any affected dependent in this Plan’s medical coverage. You must request enrollment within 60 days after the Medicaid or CHIP coverage ends. Also, if you or your eligible dependent becomes eligible under Medicaid or a State CHIP plan for financial assistance to pay for health coverage under this Plan, and you may be able to enroll yourself and any affected dependent in this Plan. You must request enrollment within 60 days of the date a government agency determines that you are eligible for that financial assistance.

To request special enrollment or obtain more information, you can contact the Benefits Service Center at the address provided in this document.

**Change in Cost or Coverage**

You may be eligible to make certain mid-year election changes (if not made automatically) in response to a change in cost or coverage, such as:

- A change in your cost for a benefit option may result in an automatic adjustment in your before-tax contributions to the flexible benefit plan;
- A significant change in your cost for a benefit option for which you may generally increase or decrease contributions, elect another option providing similar coverage, or drop coverage if your cost increases and similar coverage is not available;
- A significant curtailment of coverage, for which you may elect coverage under another benefit option providing similar coverage;
- A loss of coverage (including elimination of a benefit option, exhaustion of overall lifetime or annual benefit limits, a substantial decrease in health care providers, a reduction in benefits for a current medical condition or treatment) for which you may either elect similar coverage under another benefit option or no coverage if no similar coverage is available;
- The addition of a new benefit option choice or significant improvement of an existing choice, for which you may revoke your existing election and elect to receive coverage under the new or improved benefit option choice;
• A change made by a family member under another employee benefit plan with a different plan year than this Plan, may allow you to make changes to coordinate with that family member’s changes
• A change made under another employee benefit plan because of a special enrollment right or change in family status or similar event, may allow you to make changes under this Plan to coordinate with the change made by your family member under that other plan; or
• A loss of coverage under a group health plan sponsored by a governmental institution or part of an educational institution.

You can make a new election in response to a change in cost or coverage only if the election is on account of and consistent with the change in cost or coverage. Please note that election changes are not automatically permitted because of all changes in cost or coverage. JHU will determine if a particular change in cost or coverage described above results in an opportunity for employees to change their elections. Also, note that you may not change your elections under the health care flexible spending account in response to a change in cost or coverage.

Other Qualifying Events

Other qualifying events include:
• A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires you or another individual to provide accident or health coverage for your child or a dependent foster child; or
• You, your spouse, domestic partner or dependent become covered or cease to be covered under Medicare or Medicaid.

Leaves of Absence

While you are on an approved leave of absence including Family and Medical Leave (FML), you may continue your flexible benefit plan elections. The Benefits Service Center will notify you of your required benefit contributions during your leave of absence. Failure to make payment for the benefit plans you choose to continue while on leave of absence will result in the loss or cancellation of coverage.

While on a leave of absence without pay, including FML:
• Medical, dental, life, dependent life insurance and short-term disability benefits (for up to three months) will be available on the same cost-sharing basis. Payment will be made in after-tax dollars;
• Payments from your health care flexible spending account would be permitted (not for premiums) for eligible health care expenses you incurred during the leave if contributions continue to be made after-tax as a continuation of coverage under COBRA; and
• AD&D does not continue while on a leave of absence without pay.

Rehire Information

If you have been employed for one continuous year in a benefits eligible status, and your employment is terminated involuntarily due to reduction in force and you are rehired within 12 months, or if you voluntarily resign in good standing and are rehired within six months (but later than 30 days) following your termination, you will be eligible for the benefits associated with the new position. However, if you are rehired within 30 days of termination (and within the same Plan Year), all your previous benefit elections may be reinstated, including your flexible spending account elections. You can also make new elections upon rehire.
If you are rehired after a longer period than described above following your termination, you will be eligible for benefits as a new hire subject to any waiting period that applies to new hires. You should contact the Benefits Service Center regarding your benefit elections upon rehire.

**Before-tax Contributions**

Contributions you make toward medical, dental, supplemental life insurance, AD&D (if applicable), short-term disability and flexible spending accounts generally are deducted from your paycheck before FICA (Social Security and Medicare taxes), federal income tax and most state and local income taxes are deducted. By paying for benefits on a before-tax basis, you reduce your taxable income — which reduces the taxes you pay.

Because your before-tax contributions to the Plan are not treated as income for Social Security purposes, your future Social Security benefits may be slightly lower than they would have been in the absence of your before-tax contributions.

Please note: The value of JHU-provided health coverage for domestic partners and their children, if they are not also dependents for purposes of federal income tax, is considered taxable income (“imputed income”). The total amount of this imputed income, if applicable, is shown on your year-end W-2 form. Additionally, your employee contributions for health coverage for domestic partners and their children, if they do not qualify as your dependents under the federal income tax rules, are taken from your pay on an after-tax basis.

Federal law requires you to pay income taxes on the value of your life insurance coverage (basic plus supplemental) over $50,000. That's because JHU pays the full cost of your basic coverage and you pay the cost of your supplemental coverage. The value of the cost of life insurance coverage over $50,000 is called “imputed income.” This amount is shown on your year-end W-2 form.

Please note: Under federal tax law, neither the dependent care FSA nor the health care FSA may be used for expenses of domestic partners or the children of domestic partners unless they qualify as your eligible dependent under the specific federal tax law definitions that apply to dependent care and health care FSAs.

**Salary Tier Contributions (Faculty and Staff Only)**

If you are eligible for JHU coverage as of January 1 of the plan year, your medical contributions for CareFirst BlueCross BlueShield Medical and EHP are based on your salary as of January 1. If you become eligible at a later date, your coverage will be based on your salary on your eligibility date. The salary tiers are as follows:

- $40,000 or less
- $40,001 - $60,000
- $60,001 - $80,000
- $80,001 - $120,000
- $120,001 - $200,000
- $200,001+

Employees in lower salary tiers (e.g., < $40k, $40k-$60k) will pay a smaller portion of overall health care premiums than employees in higher salary bands (e.g., $60k-$80k, $80k-$120k, $120k-$200k, >$200k).

Please note: Faculty and staff will receive a medical waiver credit if medical coverage through JHU is declined. The medical waiver credit is $800, if your salary is $40,000 or less, and $500 if your salary is more than $40,000.
**Administrative Facts**

The myChoices Program is administered by JHU. JHU has full discretionary authority to determine eligibility under the Plan and to interpret the provisions of the Plan. The benefit options provided through the flexible benefit plan are governed by separate plan documents and contracts and are subject to the administrative and claims procedures set forth in those documents.

**For Other Information, Go To...**

<table>
<thead>
<tr>
<th>Changes to Your Benefits</th>
<th>For information on how changes in family or work situations may affect your coverage</th>
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</thead>
<tbody>
<tr>
<td>Administrative Information</td>
<td>For important facts about plan administration and your rights under ERISA</td>
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<tr>
<td>Resources</td>
<td>For a list of contacts and available resources</td>
</tr>
</tbody>
</table>
Chapter 2 – Changes to Your Benefits

**FAST FACTS**

- You should take a fresh look at your benefits whenever you experience a major qualifying event — such as marriage or having a baby — to be sure that what’s in place still meets your needs. You have just 30 days from the date of your qualifying event to make changes to your benefits.
- You will need to follow specific steps — within specific time frames — to continue certain benefits, if eligible, when certain events occur.
- Your coverage may change when certain employment changes take place; such as if you take a leave of absence or disability leave, or you retire or otherwise terminate employment.

There's a good chance that your personal situation — and your personal needs — will change at some point during your career with JHU. That's why JHU offers you the myChoices Program, a flexible benefits program.

The myChoices Program is subject to the Internal Revenue Code (IRC) rules. That means you have options available to you that allow you to adapt your benefits to certain changes in your personal needs and priorities; your contributions to the Plan may be made with before-tax dollars. That also means JHU has to abide by certain limitations and restrictions that apply under the IRC, including when and how changes to your benefits can be made.

When you enroll in your benefits during annual enrollment, the benefits you elect normally cannot be changed during the Plan Year until the next annual enrollment period. However, midyear changes are allowed in limited circumstances related to special enrollment rules, changes in status, or changes in the cost or coverage available under your benefit program. Depending on the qualifying event you experience, you may be able to make midyear changes to your benefits.

This chapter covers the most common qualifying events and, for each, summarizes things you should consider and actions you may want to take. It also refers you to the appropriate chapters of this document for more detailed information.

**Keep an Eye on the Calendar**

To change your benefit elections to correspond with a qualifying event, you must contact the Benefits Service Center (BSC) within 30 days of the qualifying event (except as otherwise provided in this section). If you do not make changes within the required time period, you may have to wait until the next annual enrollment period to make changes. Once the new election has been made and all required forms are submitted to the Benefits Service Center, the change will be made as soon as administratively reasonable after you submit the forms. In the case of birth or adoption, medical coverage will be applied retroactively to the date of the event.

*Please note: The information in this section applies to eligible JHU employees. To determine whether you are eligible, review the explanation of eligibility criteria in Chapter 1, “The Big Picture,” and the specific eligibility requirements outlined in each benefit plan or program description.*
What If...You Are a New Employee (or a Change in Your Employment Status Makes You Eligible for the Plan)

Step 1: Things to Consider

<table>
<thead>
<tr>
<th>Think about this…</th>
<th>More details provided in…</th>
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</thead>
<tbody>
<tr>
<td>Are you or your spouse or domestic partner eligible for health benefits from another source? If so, consider whether you want or need health care coverage through JHU.</td>
<td>Medical and Dental</td>
</tr>
<tr>
<td>Do you expect to have health care expenses that aren’t reimbursed through your health care coverage from JHU or another plan? If so, consider contributing to a health care flexible spending account, which lowers your cost for eligible out-of-pocket health care expenses by letting you pay for these expenses with before-tax dollars.</td>
<td>Flexible Spending Accounts</td>
</tr>
<tr>
<td>Will you be using dependent care so you and your spouse or domestic partner can work? If so, consider contributing to a dependent care flexible spending account, which allows you to pay for certain dependent care expenses on a before-tax basis.</td>
<td>Flexible Spending Accounts</td>
</tr>
<tr>
<td>Will your family be able to meet financial obligations if you die? JHU offers a variety of life and accident insurance coverage options.</td>
<td>Life, AD&amp;D, and Business Travel Accident Insurance</td>
</tr>
<tr>
<td>Will you be able to meet day-to-day financial obligations if you are disabled and unable to work? You may elect short-term disability (STD) coverage. JHU automatically provides long-term disability (LTD) at no cost to you. (LTD is subject to a one-year waiting period, which is waived if you come to JHU within three months of leaving employment at an organization where you had similar coverage for at least one year.)</td>
<td>Disability Benefits</td>
</tr>
</tbody>
</table>

Step 2: Take Action

If you decide you would like coverage under any of the following benefits, you must enroll by the return date shown on your myChoices Enrollment form:

- Medical coverage;
- Dental coverage;
- Voluntary vision coverage;
- Health care flexible spending account (calendar year election);
- Dependent care flexible spending account (calendar year election);
- Life insurance;
- AD&D; and
- Short-term disability.
As soon as possible, you should name your beneficiaries for:

- Life insurance and AD&D (basic and supplemental);
- Business travel accident insurance (unless specifically designated on a separate beneficiary form, the beneficiary for your life insurance will be assigned as beneficiary);
- Critical illness insurance, if applicable; and
- Accident insurance, if applicable.

If you have a spouse or domestic partner* for whom you will be electing coverage, you must complete an Affidavit of Marriage Domestic Partnership.

*Must qualify for coverage under the JHU Domestic Partner Benefits Policy.

**What If...You Change Your Marital Status**

**You Get Married or Enter a Domestic Partnership**

**Step 1: Things to Consider**

<table>
<thead>
<tr>
<th>Think about this…</th>
<th>More details provided in…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is your spouse or domestic partner eligible for health benefits or other insurance coverage from another source? If so, consider both your and your spouse's/dominant partner's enrollment choices.</td>
<td>Medical, Dental, Life, AD&amp;D, and Business Travel Accident Insurance, Flexible Spending Accounts</td>
</tr>
<tr>
<td>If you enter into a domestic partner relationship, do you meet the requirements to apply for domestic partner coverage? You must qualify for coverage under the JHU Domestic Partnership Benefits Policy.</td>
<td>The Big Picture</td>
</tr>
<tr>
<td>Does your spouse or domestic partner have any dependents? They may be eligible for coverage under certain of JHU's benefits once you are married or have met the conditions for covering a domestic partner under JHU’s Domestic Partnership Benefits Policy.</td>
<td>Medical, Dental, Life, AD&amp;D, and Business Travel Accident Insurance</td>
</tr>
<tr>
<td>Is your current life and AD&amp;D insurance coverage still sufficient? You may want to consider increasing the amount of your life and AD&amp;D insurance coverage.</td>
<td>Life, AD&amp;D, and Business Travel Accident Insurance</td>
</tr>
<tr>
<td>Who is your beneficiary for JHU’s life, AD&amp;D, and business travel accident insurance benefits? You may want to name your spouse or domestic partner as a beneficiary under one or more of these plans.</td>
<td>Life, AD&amp;D, and Business Travel Accident Insurance</td>
</tr>
<tr>
<td>Do you want to purchase dependent life insurance coverage? You may want to enroll your spouse or domestic partner (and eligible dependents) for dependent life insurance.</td>
<td>Life, AD&amp;D, and Business Travel Accident Insurance</td>
</tr>
</tbody>
</table>
Step 2: Take Action

If you will be electing coverage for your spouse or domestic partner,* you must complete an Affidavit of Marriage/Domestic Partnership. To obtain the appropriate forms, visit the Benefits website at http://benefits.jhu.edu/resources/forms.cfm or contact the Benefits Service Center.

*Must qualify for coverage under the JHU Domestic Partner Benefits Policy.

If you decide you would like to change your coverage under any of the following benefits, you must enroll for the following no later than 30 days after you are married or meet the requirements under JHU’s Domestic Partner Benefits Policy:

- **Medical, dental and voluntary vision plans**: You may enroll your spouse or domestic partner and any eligible dependents in your current plan, or drop JHU coverage if you enroll in your spouse’s or domestic partner’s plan(s).
- **Flexible spending accounts**: You may begin making contributions, or change the amount you contribute for health care and/or dependent care (for domestic partnerships, changes are permitted only if your domestic partner or a child of your partner becomes your dependent for purposes of the health care FSA or a qualifying individual for purposes of the dependent care FSA).
- **Supplemental life insurance**: You may enroll, increase or decrease coverage. An increase in coverage may be subject to Statement of Health requirements.
- **Dependent life insurance**: You may enroll for coverage for your spouse or domestic partner or any other eligible new dependents.
- **AD&D insurance** (if applicable): You may enroll, increase or decrease coverage.
- **Short-term disability**: You may enroll or drop coverage.

As soon as possible, you should:

- Update your tax withholding status and address, if necessary, through Employee Self Service at Johns Hopkins at https://my.johnshopkins.edu;
- Update your name and emergency contact information through Employee Self Service; and
- Review your beneficiary designations (online or by contacting the Benefits Service Center) for:
  - Life insurance & AD&D (basic and supplemental) (if applicable);
  - Business travel accident insurance;
  - Critical illness insurance (if applicable); and
  - Accident insurance (if applicable).

You should also review your beneficiary designations for your retirement savings plans. Contact your investment provider for more information.

To obtain the appropriate forms, visit the Benefits website at http://benefits.jhu.edu/resources/forms.cfm or contact the Benefits Service Center.

Domestic partners and children of domestic partners are eligible for coverage under the medical, dental and voluntary vision plans. But, under federal tax law, neither the dependent care FSA nor the health care FSA may be used for expenses of domestic partners or the children of a domestic partner unless they qualify as your eligible dependent under the specific federal tax law definitions that apply to dependent care and health care FSAs.

Please note: Under federal law, the value of benefits for domestic partners and their child(ren) is taxable to the employee for federal income purposes; however, if a domestic partner and his/her child(ren) are qualified tax dependents of the employee under the federal tax law, then the value is not taxable to the employee.
You Get Divorced or Your Domestic Partnership Ends

Step 1: Things to Consider

<table>
<thead>
<tr>
<th>Think about this…</th>
<th>More details provided in…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you covered under your former spouse's or domestic partner's health insurance? If so, you may want to enroll for medical and other health care coverage under JHU's options.</td>
<td>Medical and Dental</td>
</tr>
<tr>
<td>Do you have any dependents? If so, determine if they will be covered by your JHU health care coverage or your former spouse’s or domestic partner’s coverage.</td>
<td>The Big Picture</td>
</tr>
<tr>
<td>Was your former spouse or domestic partner contributing to a dependent care flexible spending account? If so, limits on married couples' contributions no longer apply. You may want to adjust your contributions.</td>
<td>Flexible Spending Accounts</td>
</tr>
<tr>
<td>Are you contributing to the health care spending account? If your marriage or partnership ends, you may no longer be reimbursed for expenses incurred by your former spouse or by a partner or child who no longer qualifies as your dependent for health FSA purposes.</td>
<td>Flexible Spending Accounts</td>
</tr>
<tr>
<td>Is your former spouse or former domestic partner the beneficiary for your life and AD&amp;D insurance coverage? If your former spouse or domestic partner is your current beneficiary, he or she will continue as your beneficiary until you designate someone else.</td>
<td>Life, AD&amp;D, and Business Travel Accident Insurance</td>
</tr>
<tr>
<td>Do you or any of your family members need help through this difficult time? The Faculty and Staff Assistance Program can help you cope with this change, talk to your children about the termination of your marriage or domestic partnership and anticipate their needs.</td>
<td>Faculty and Staff Assistance Program</td>
</tr>
</tbody>
</table>

Step 2: Take Action

Complete and submit the JHU Termination Statement of Marriage/ Domestic Partnership form within 30 days of the termination of your marriage or domestic partnership.

This form is available online at [http://benefits.jhu.edu/resources/forms.cfm](http://benefits.jhu.edu/resources/forms.cfm), or you can contact the Benefits Service Center. Coverage for a former spouse or domestic partner or for any other person who ceases to qualify as your dependent for purposes of a particular benefit will automatically terminate, subject to COBRA continuation requirements, if applicable, based on the normal termination provisions that apply to that benefit.

If you decide you would like to change your coverage under any of the following benefits, you must do so no later than 30 days after you become divorced or your domestic partnership ends. In addition to cancelling coverage for your former spouse or former domestic partner, under certain circumstances, you may make other changes in coverage for yourself and your dependents that are consistent with the divorce or termination of domestic partnership. Those changes may include:
• **Medical, dental and voluntary vision plans:**
  – You may enroll yourself or your eligible dependents in coverage under this plan (if you or your dependents lose eligibility for coverage under another plan); and
  – You may change your coverage level to individual coverage if you no longer need to cover any dependents, or you may change your coverage level to adult and child(ren) if you need to continue to cover eligible dependent children.

• **Health care flexible spending account:**
  – If you were using your health care FSA to pay eligible expenses of your spouse or any other person whose expenses will no longer qualify, you may decrease the amount you contribute to the FSA.
  – If your spouse or domestic partner was using a health care FSA or another health plan sponsored by his/her employer to pay for some of your health care expenses, you may enroll in or increase your contributions to our health care FSA if you wish to use the FSA to pay those expenses.
  *Please note that up to $500 in unused health care FSA contributions will automatically be carried over to the next calendar year and can be applied to eligible expenses in that year.

• **Dependent care flexible spending account:**
  – If your employment-related dependent care expenses for a qualifying dependent increase because of the divorce, you can increase your contributions or enroll in the dependent care FSA.
  – If your employment-related dependent care expenses decrease because of a divorce or termination of domestic partnership (e.g., because you have fewer qualifying dependents), you may decrease your contributions to the FSA.

• **Supplemental life insurance:** You may enroll, increase or decrease coverage. An increase in coverage may be subject to Statement of Health requirements.

• **Dependent life insurance:** You may drop coverage for your former spouse or domestic partner.

• **AD&D insurance** (if applicable): You may enroll, increase or decrease coverage.

• **Short-term disability:** You may enroll or drop coverage.

Following your legal separation or divorce, you or your former spouse must promptly notify JHU’s Benefits Service Center of the change in your marital status for your spouse to be eligible to elect to continue any health coverage under COBRA. You (or your spouse or former spouse) must provide this notice no later than 60 days from the date of the event, or the date coverage would otherwise end due to the event, whichever is later. (A termination of a domestic partnership is never a COBRA event, so no COBRA coverage would be available for anyone because of the end of a domestic partnership.) However, JHU voluntarily offers similar non-COBRA continuation coverage for an eligible domestic partner (or a child of either) who loses coverage because of divorce or legal separation or a termination of domestic partnership. To qualify, notice of the event must be provided no later than 60 days from the date of the event, or the date coverage would otherwise end due to the event, whichever is later.

As soon as possible, you should:
• Update your tax withholding status and address, if necessary, through Employee Self Service at Johns Hopkins at https://my.johnshopkins.edu;
• Update your name and emergency contact information, by using Employee Self Service; and
• Review your beneficiary designations (online or by contacting the Benefits Service Center) for:
  – Life insurance and AD&D (basic and supplemental) (if applicable);
  – Business travel accident insurance;
  – Critical illness insurance (if applicable); and
  – Accident insurance (if applicable).

You should also review your beneficiary designations for your retirement savings plans. Contact your investment provider for more information.
To obtain the appropriate forms, visit the Benefits website at http://benefits.jhu.edu/resources/forms.cfm or contact the Benefits Service Center.

Please note: You are required to provide proof of your dependents’ eligibility upon request. False or misrepresented eligibility information will cause both your coverage and your dependents’ coverage to be irrevocably terminated (retroactively to the extent permitted by law), and could be grounds for employee discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

Your Spouse or Domestic Partner Dies

Step 1: Things to Consider

<table>
<thead>
<tr>
<th>Think about this…</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Were you or any dependents covered under your spouse’s or domestic partner’s health insurance? If so, you may want to enroll for medical and other health care coverage under JHU’s options.</td>
<td>[Medical and Dental]</td>
</tr>
<tr>
<td>Was your spouse or domestic partner contributing to a health care or dependent care FSA? If so, you may want to adjust your contributions to JHU’s FSA.</td>
<td>[Flexible Spending Accounts]</td>
</tr>
<tr>
<td>Do you or any of your family members need help through this difficult time? The Faculty and Staff Assistance Program can help you cope with this change, talk to your children about the loss and anticipate their needs.</td>
<td>[Faculty and Staff Assistance Program]</td>
</tr>
</tbody>
</table>

Step 2: Take Action

If you decide you would like to change your coverage under any of the following benefits, you must do so no later than 30 days after your spouse’s or domestic partner’s death. Contact the Benefits Service Center for details regarding changes to your benefit plans or to file a death claim for your spouse or domestic partner if you elected dependent life insurance.

- **Medical, dental and voluntary vision plans**: You may enroll any eligible dependent who has lost coverage under your spouse or domestic partner’s plan in your current plan, or drop JHU coverage for your spouse or domestic partner.
- **Flexible spending accounts**: You may begin making contributions, or change the amount you contribute for health care and/or dependent care if the death causes loss of coverage for your expenses under your spouse’s or domestic partner’s plan.
- **Supplemental life insurance**: You may enroll, increase or decrease your coverage amount. An increase in coverage amount may be subject to Statement of Health requirements.
- **Dependent life insurance**: You may drop coverage for your spouse or enroll a dependent who has lost coverage under your spouse’s plan.
- **AD&D insurance** (if applicable): You may enroll.

As soon as possible you should:

- Update your tax withholding status and address, if necessary, through Employee Self Service at Johns Hopkins at https://my.johnshopkins.edu;
- Update your emergency contact information through Employee Self Service; and
• Review your beneficiary designations (online or by contacting the Benefits Service Center) for:
  – Life insurance and AD&D (basic and supplemental) (if applicable);
  – Business travel accident insurance;
  – Critical illness insurance (if applicable); and
  – Accident insurance (if applicable).

You should also review your beneficiary designations for your retirement savings plans. Contact your investment provider for more information.

To obtain the appropriate forms, visit the Benefits website at http://benefits.jhu.edu/resources/forms.cfm or contact the Benefits Service Center.

What If...You Have a Change in the Number of Your Dependents

Please note: You are required to provide proof of your dependents’ eligibility upon request. False or misrepresented eligibility information will cause both your coverage and your dependents’ coverage to be irrevocably terminated (retroactively to the extent permitted by law), and could be grounds for employee discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

You Have a Baby or Adopt a Child

Step 1: Things to Consider

<table>
<thead>
<tr>
<th>Think about this...</th>
<th>More details provided in...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your spouse or domestic partner have health benefits or other insurance coverage from another source? If so, think about the most effective coverage choices. You have 30 days to add your new child to JHU’s group health plan. Medical coverage will be applied retroactively to the date of the event.</td>
<td>Medical and Dental</td>
</tr>
<tr>
<td>Will you be using dependent care so you (and your spouse, if applicable) can work? The dependent care flexible spending account may reduce your taxes, lowering your cost for this expense.</td>
<td>Flexible Spending Accounts</td>
</tr>
<tr>
<td>How will you be paid for any time missed due to the birth or adoption of a child? Family Leave provides paid time off for activities related to the care and well-being of a newborn or newly adopted child.</td>
<td>Leaves &amp; Disability</td>
</tr>
<tr>
<td>Do you need to change your life and/or AD&amp;D insurance coverage? You may want to consider electing coverage or increasing your coverage under one or both of these plans.</td>
<td>Life, AD&amp;D, and Business Travel Accident Insurance</td>
</tr>
<tr>
<td>Do you need help finding the right child care provider? The Office of Work, Life and Engagement provides resources and referrals for family services and care.</td>
<td><a href="http://www.hopkinsworklife.org">www.hopkinsworklife.org</a></td>
</tr>
</tbody>
</table>
### Do you need help dealing with the changes and added responsibilities that are associated with becoming a parent?

The Faculty and Staff Assistance Program provides information, resources, and services to help you cope with change and care for your family.

### Faculty and Staff Assistance Program

### Step 2: Take Action

Before the child’s arrival, you should:

- Confirm what benefits are available (e.g. short-term disability) if you have medical complications during your pregnancy that prevent you from working;
- Confirm what benefits are available after you give birth or adopt a child (e.g., Family Leave; Adoption Assistance plan) and what resources are available (e.g., The Office of Work, Life and Engagement);
- If you are not able to afford the health care premiums, contact your State Medicaid or CHIP office to find out if premium assistance is available; and
- Advise your supervisor and Human Resources of your plans to take time off and any intermittent changes in schedule for your return.

You have 30 days after the birth or adoption of a child to make changes (that are consistent with the birth or adoption) to your benefits. Those changes may include the following:

- **Medical, dental and voluntary vision plans:**
  - You may enroll your new child in your current plan.
  - You may enroll yourself, your spouse or your domestic partner if either of you were not previously enrolled.
  - Under certain conditions, you may be able to enroll other eligible dependents that were not previously covered (if that is consistent with the birth or adoption).

- **Flexible spending accounts:** You may begin making contributions or increase the amount you contribute for health care and/or dependent care. In some cases, you may be able to decrease the amount that you contribute. For example, if your spouse previously worked but decides to stay home to care for the new child along with any other children, you could elect to stop your dependent care contributions because you would no longer need to pay someone for employment-related dependent care. Please note that up to $500 in unused health care FSA contributions will automatically be carried over to the next calendar year and can be applied to eligible expenses in that year.

- **Supplemental life insurance:** You may enroll, increase or decrease coverage. An increase in coverage may be subject to Statement of Health requirements.

- **Dependent life insurance:** You may enroll for coverage for any eligible new participants.

- **AD&D insurance** (if applicable): You may enroll, increase coverage or decrease coverage.

- **Short-term disability:** You may enroll or drop coverage.

As soon as possible, you should:

- Update your tax withholding status, if necessary; through Employee Self Service at Johns Hopkins at [https://my.johnshopkins.edu](https://my.johnshopkins.edu);
- Update your emergency contact information through Employee Self Service; and
- Review your beneficiary designations (online or by contacting the Benefits Service Center) for:
  - Life insurance and AD&D (basic and supplemental) (if applicable);
  - Business travel accident insurance;
  - Critical illness insurance (if applicable); and
Changes to Your Benefits

– Accident insurance (if applicable).

You should also review your beneficiary designations for your retirement savings plans. Contact your investment provider for more information.

To obtain the appropriate forms, visit the Benefits website at http://benefits.jhu.edu/resources/forms.cfm or contact the Benefits Service Center.

A Dependent No Longer Meets Eligibility Requirements

Step 1: Things to Consider

<table>
<thead>
<tr>
<th>Think about this…</th>
<th>More details provided in…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will your dependent need to continue health care coverage or is coverage available elsewhere? Previously elected coverage generally is available under COBRA.</td>
<td>Medical and Dental</td>
</tr>
</tbody>
</table>

Step 2: Take Action

Dependent children covered under the Plan who no longer meet eligibility requirements on account of age may continue medical and dental coverage through COBRA. See, “Continued Coverage Under COBRA” in Chapter 3, “Medical Benefits” for more information.

Please note: JHU’s health plans voluntarily provide “COBRA-like” health care continuation rights to covered domestic partners and covered dependent children of domestic partners under the same types of terms and conditions that apply to spouses and dependent children entitled to COBRA rights under federal law. Please contact the Plan Administrator if you have any questions about these continuation rights voluntarily extended to these individuals.

Coverage may be continued for dependent children up to any age if they cannot support themselves because of a mental or physical disability (certification of disability is required) that occurred before they reached the age limit when coverage would normally end.

Of course, coverage for a dependent child will automatically be dropped in accordance with the Plan’s normal termination of coverage provisions, after JHU learns that the child is no longer eligible for coverage, subject to any continuation requirements. If you would like to change your coverage when a dependent no longer meets eligibility requirements, you must make the changes to your election no later than 30 days after the qualifying event.

• Medical, dental and voluntary vision plans: You may drop coverage for your dependent.
• Flexible spending accounts: You may decrease your contributions to the health care flexible spending account. You may decrease your contributions to the dependent care flexible spending account if that account was being used to pay for dependent care expenses for care of that child.
• Supplemental life insurance: You may decrease your coverage amount.
• Dependent life insurance: You may drop coverage if you no longer have an eligible dependent.
• AD&D insurance (if applicable): You may drop coverage if you no longer have an eligible dependent.
• Short-term disability: You may drop coverage.
As soon as possible you should:

• Update your tax withholding status and address, if necessary; through Employee Self Service at Johns Hopkins at https://my.johnshopkins.edu;

• Update your emergency contact information through Employee Self Service; and

• Review your beneficiary designations (online or by contacting the Benefits Service Center) for:
  – Life insurance and AD&D (basic and supplemental) (if applicable);
  – Business travel accident insurance;
  – Critical illness insurance (if applicable); and
  – Accident insurance (if applicable).

You should also review your beneficiary designations for your retirement savings plans. Contact your investment provider for more information.

To obtain the appropriate forms, visit the Benefits website at http://benefits.jhu.edu/resources/forms.cfm or contact the Benefits Service Center.
A Dependent Child Dies

Step 1: Things to Consider

Think about this… | More details provided in…
--- | ---
Do you or any of your family members need help through a difficult time? The Faculty and Staff Assistance Program can help you cope with a death, talk to other dependents, and anticipate their needs. | Faculty and Staff Assistance Program

Step 2: Take Action

If you would like to change your coverage under any of the following benefits, you must do so no later than 30 days after your dependent child’s death. Contact the Benefits Service Center for details regarding changes to your benefit plans and to file a death claim if you elected dependent life insurance.

- **Medical, dental, and voluntary vision plans**: You should drop coverage for your dependent.
- **Flexible spending accounts**: You may decrease your election.
- **Supplemental life insurance**: You may enroll, increase or decrease your coverage amount. An increase in coverage amount may be subject to Statement of Health requirements.
- **Dependent life insurance**: You should drop coverage if you no longer have an eligible dependent.
- **AD&D insurance** (if applicable): You should drop coverage if you no longer have an eligible dependent.
- **Short-term disability**: You may increase or drop coverage.

As soon as possible you should:

- Update your tax withholding status and address, if necessary, through Employee Self Service at Johns Hopkins at [https://my.johnshopkins.edu](https://my.johnshopkins.edu);
- Update your emergency contact information through Employee Self Service; and
- Review your beneficiary designations (online or by contacting the Benefits Service Center) for:
  - Life insurance and AD&D (basic and supplemental) (if applicable);
  - Business travel accident insurance;
  - Critical illness insurance (if applicable); and
  - Accident insurance (if applicable).

You should also review your beneficiary designations for your retirement savings plans. Contact your investment provider for more information.

To obtain the appropriate forms, visit the Benefits website at [http://benefits.jhu.edu/resources/forms.cfm](http://benefits.jhu.edu/resources/forms.cfm) or contact the Benefits Service Center.
What If...There is a Change in Your Employment Status

You Want to Take Time Off for Family and Medical Leave

Step 1: Things to Consider

<table>
<thead>
<tr>
<th>Think about this…</th>
<th>More details provided in…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you be paid for any portion of your Family and Medical Leave? You should review JHU’s Family and Medical Leave Policy in the Human Resources Policy Manual.</td>
<td>Human Resources Policy Manual</td>
</tr>
<tr>
<td>Do you want to change any of your benefits while on Family and Medical Leave? Under certain circumstances you are allowed to change your elections.</td>
<td>The Big Picture</td>
</tr>
<tr>
<td>Will JHU hold your position while you are on Family and Medical Leave? JHU will hold your position for you for up to 12 weeks or longer, if required by federal or state law; see JHU’s Family and Medical Leave Policy in the Human Resources Policy Manual for details.</td>
<td>Human Resources Policy Manual</td>
</tr>
<tr>
<td>Do you or any of your family members need help through a difficult time? The Faculty and Staff Assistance Program can help you cope and anticipate your needs.</td>
<td>Faculty and Staff Assistance Program</td>
</tr>
</tbody>
</table>

Step 2: Take Action

If you want to apply for Family and Medical Leave, before your leave begins (30 days prior, when possible):
- Notify your supervisor or Human Resources to apply for Family and Medical Leave.
- Review your benefit elections and your options for changing your benefits while on Family and Medical Leave.

Although not all benefits continue during a leave of absence, generally, most benefits do continue, depending on the type of leave. AD&D insurance does not continue during a leave of absence without pay. If your benefits continue, you will be billed for your share of the cost for continuing benefits. Failure to make payment for the benefit plans you choose to continue while on leave of absence will result in the loss or cancellation of coverage. During your leave, you will need to submit any required periodic health care provider certification of illness to Occupational Health Services. This is provided if you are on leave to care for a family member with a serious health condition or to care for your own serious health condition.

You should re-enroll in any benefits you would like to resume (if eligible) within 30 days of your return.
You Become Disabled

Step 1: Things to Consider

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<tr>
<th>Think about this…</th>
<th>More details provided in…</th>
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<tbody>
<tr>
<td><strong>How long do you expect to be unable to work?</strong> If you elected short-term disability and your claim is approved by The Hartford Insurance Company, you are eligible for disability benefits after 14 consecutive days for up to 11 weeks of disability. Long-term disability benefits begin after 90 consecutive days of disability, if it is determined by The Hartford that you are eligible. All benefits-eligible JHU employees have long-term disability coverage subject to a one year waiting period, which is waived if you come to JHU within three months of being covered by a similar plan through another employer for at least one year.</td>
<td>Disability</td>
</tr>
<tr>
<td><strong>Do you want to continue any supplemental life insurance you have elected?</strong> JHU continues your JHU-paid benefits — including basic life insurance — while you are receiving JHU disability benefits. You may continue your supplemental life insurance by paying the premiums on an after-tax basis.</td>
<td>Life, AD&amp;D, and Business Travel Accident Insurance</td>
</tr>
<tr>
<td><strong>Is the stress of your disability presenting personal concerns for you or your family members?</strong> You may continue to access the Faculty and Staff Assistance Program for guidance and support.</td>
<td>Faculty and Staff Assistance Program</td>
</tr>
</tbody>
</table>

Step 2: Take Action

As soon as you miss work, be sure you:

- Inform your supervisor immediately of your absence, stating the reason and expected duration;
- If you expect that your absence will last more than 14 consecutive days, notify your supervisor and Human Resources. Contact the short-term disability (STD) carrier to file a claim for STD benefits (if enrolled);
- Although not all benefits continue during a leave of absence, generally, most benefits do continue, depending on the type of leave. If your benefits continue, you will be billed for your share of the cost for continuing benefits. You are required to make payments while on a leave of absence. Failure to do so will result in the loss or cancellation of coverage; and
- Review your benefit elections and your options for changing your benefits while on Family and Medical Leave.

If you expect to be absent for more than 90 days:

- You should contact the long-term disability (LTD) insurance carrier to file a claim for LTD benefits (if eligible); and
- You will be billed for your share of the cost of your elected benefits if on leave without pay.

When you’re ready to return to work, you will need to coordinate your return to work date with your supervisor and through Occupational Health Services.
Your Employment Status Changes Resulting in Your Loss of Plan Eligibility (e.g., From Non-Bargaining to Bargaining, or from Full-Time to Another Status)

Step 1: Things to Consider

<table>
<thead>
<tr>
<th>Think about this…</th>
<th>More details provided in…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you need to make new myChoices Program elections? A change in your eligibility means that you’ll need to investigate JHU’s benefit options based on your new employment status. Be sure to review the appropriate plan information.</td>
<td>The Big Picture</td>
</tr>
<tr>
<td>Will you need to continue your health care coverage or is coverage available elsewhere? Previously elected health coverage is available to you under COBRA, if your coverage would otherwise end because of a reduction in your hours or a termination of employment. You will be required to pay 102% of the full cost of coverage on an after-tax basis.</td>
<td>Medical and Dental</td>
</tr>
</tbody>
</table>

Step 2: Take Action

Although you are staying at JHU, your status change means you will need to enroll for the appropriate benefits that are available to you within 30 days of the qualifying event. You will need to cease any contributions you are making under this Plan toward your benefit elections for which you are no longer eligible, including: flexible spending accounts, supplemental life insurance, dependent life insurance, AD&D insurance, and short-term disability.

If you are losing eligibility for medical and dental coverage because of an employment status change and you want to continue the medical and dental coverage you had immediately before your loss of eligibility, you must return the COBRA application form, which will be automatically sent to you following your loss of eligibility, to the COBRA administrator by the date specified on your COBRA letter. The COBRA letter also will provide information about electing COBRA coverage for a health care FSA, if applicable.
You Leave JHU (Other Than Retirement)

Step 1: Things to Consider

<table>
<thead>
<tr>
<th>Think about this…</th>
<th>More details provided in…</th>
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</thead>
<tbody>
<tr>
<td><strong>Will you need to continue your health care coverage or is coverage available elsewhere?</strong> Generally, you are eligible to elect COBRA following termination of employment. If you elect COBRA coverage, you may continue JHU’s health care benefits for up to 18 months (29 months if you qualify for a disability extension). You will be required to pay 102% of the full cost of coverage on an after-tax basis.</td>
<td>Medical and Dental</td>
</tr>
<tr>
<td><strong>Do you want to convert your life insurance coverage (if applicable) for yourself and/or your dependents to an individual policy?</strong> You may be eligible to convert all or a portion of your life or personal accident insurance to an individual policy by applying directly to the insurance company. You must apply within 31 days after the date your coverage would otherwise end.</td>
<td>Life, AD&amp;D, and Business Travel Accident Insurance</td>
</tr>
<tr>
<td><strong>Will you have continued expenses that are eligible for reimbursement from your health care and/or dependent care flexible spending account?</strong> You may continue to submit claims up to April 30 of the following year for expenses incurred prior to your termination. For the dependent care flexible spending account, you may be reimbursed up to your account balance as of the end of the month of your termination. For the health care flexible spending account, you may be reimbursed up to the amount you elected to contribute for the year. You will not be reimbursed for claims incurred after your termination unless you elect COBRA coverage for your health care flexible spending account and make the required after-tax contributions.</td>
<td>Flexible Spending Accounts</td>
</tr>
</tbody>
</table>

Step 2: Take Action

When resigning:

- If you are a support staff or bargaining unit employee, please submit a written letter of resignation to your supervisor at least two weeks before your last day of employment.
- If you are a senior staff employee, you must give a minimum of one month’s notice of resignation.

Any separating employee must return all JHU property (keys, access cards, personal computer, credit cards, etc.).

If you want to convert your life insurance, AD&D insurance (if applicable) or long-term disability Insurance to an individual policy:

- **Life insurance:** You will be contacted by the life insurance company regarding conversion. You must respond within 30 days after coverage would otherwise end.
• **AD&D insurance** (if applicable): You will need to apply and pay the premium directly to the insurance company within 30 days after your coverage through JHU ends. You must meet any other requirements of the insurance company.

• **Long-term disability**: To be eligible to convert your LTD Insurance, you must have been covered by the plan for at least 12 consecutive months on the date your coverage ends. You must apply for coverage with the LTD Insurance company, pay the first premium within 30 days after your employment terminates, and meet any other requirements of the insurance company.

If you want to continue the medical and dental coverage you had immediately before your termination, you must return the COBRA election form sent to you following your termination, to the COBRA administrator by the date specified on your COBRA letter. The COBRA letter also will provide information about electing COBRA coverage for a Health Care FSA, if applicable.

**You Leave JHU and Are Rehired**

**Step 1: Things to Consider**

<table>
<thead>
<tr>
<th>Think about this…</th>
<th>More details provided in…</th>
<th>Except if you need to re-elect Benefits…</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Will you need to make new myChoices Program elections?</strong> If you have been employed for one continuous year in a benefits eligible status, and your employment is terminated involuntarily due to reduction in force and you are rehired within 12 months, or if you voluntarily resign in good standing and are rehired within six months (but later than 30 days) following your termination, you will be eligible for the benefits associated with the new position. However, if you are rehired within 30 days of termination (and within the same Plan Year), all your previous benefit elections may be reinstated, including your flexible spending account elections. You can also make new elections upon rehire.</td>
<td>The Big Picture, Flexible Spending Accounts</td>
<td>You will also have a 30-day period to re-elect.</td>
</tr>
</tbody>
</table>

If you are rehired after a longer period than described above following your termination, you will be eligible for benefits as a new hire subject to any waiting period that applies to new hires. You should contact the Benefits Service Center regarding your benefit elections upon rehire.

**Step 2: Take Action**

If you have been employed for one continuous year in a benefits eligible status, and your employment is terminated involuntarily due to reduction in force and you are rehired within 12 months, or if you voluntarily resign in good standing and are rehired within six months (but later than 30 days) following your termination, you will be eligible for the benefits associated with the new position. However, if you are rehired within 30 days of termination (and within the same Plan Year), all your previous benefit elections may be reinstated, including your flexible spending account elections. You can also make new elections upon rehire.
If you are rehired after a longer period than described above following your termination, you will be eligible for benefits as a new hire subject to any waiting period that applies to new hires. You should contact the Benefits Service Center regarding your benefit elections upon rehire. Refer to “What If…You Are a New Employee” in this section for additional information.

### You Retire

#### Step 1: Things to Consider

<table>
<thead>
<tr>
<th>Think about this…</th>
<th>More details provided in…</th>
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</thead>
<tbody>
<tr>
<td>Are you eligible to retire (i.e., age 55 or above with 10 or more years of continuous full-time service or any age with 30 years of continuous full-time service)?</td>
<td>Medical and Dental</td>
</tr>
<tr>
<td>If you or your spouse or domestic partner are age 65 or above, have you enrolled in Medicare Part B?</td>
<td>Medical and Dental Benefits for Retirees</td>
</tr>
<tr>
<td>Will you need to continue using your health care and/or dependent care flexible spending account?</td>
<td>Flexible Spending Accounts</td>
</tr>
<tr>
<td>Will you or your dependents need life insurance after you retire?</td>
<td>Life, AD&amp;D, and Business Travel Accident Insurance</td>
</tr>
</tbody>
</table>

#### Step 2: Take Action

At least three months prior to retirement, be sure to:

- Notify the Benefits Service Center of your intent to retire; and
- Obtain information on applying for Social Security and Medicare from your local Social Security office (once you meet the Social Security minimum retirement age).
- As soon as possible (if applicable), you should update your address through Employee Self Service at Johns Hopkins at [https://my.johnshopkins.edu](https://my.johnshopkins.edu).
What If...Your Spouse, Domestic Partner or Dependent Changes Employment Status

Step 1: Things to Consider

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<tr>
<th>Think about this…</th>
<th>More details provided in…</th>
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<tbody>
<tr>
<td>As a result of the change, are you or your spouse or domestic partner eligible for health benefits from another source, or have you lost coverage from another source? If so, consider whether you want or need health care coverage through JHU.</td>
<td>Medical and Dental</td>
</tr>
<tr>
<td>Will you be using dependent care so you and your spouse or domestic partner can work? If so, consider contributing to a dependent care flexible spending account, which allows you to pay for certain dependent care expenses on a before-tax basis.</td>
<td>Flexible Spending Accounts</td>
</tr>
<tr>
<td>Will your family be able to meet financial obligations if you die? JHU offers a variety of life and accident insurance coverage options.</td>
<td>Life, AD&amp;D, and Business Travel Accident Insurance</td>
</tr>
</tbody>
</table>

Step 2: Take Action

A number of events might cause a spouse, domestic partner or dependent to cease to be eligible for coverage under another employer’s plan, or that might cause a spouse or domestic partner to gain eligibility for coverage under another employer’s plan.

You may change your elections if eligibility for coverage is affected when your spouse, domestic partner or dependent:

- Terminates employment;
- Commences employment;
- Commences unpaid leave;
- Experiences a change in employment status that causes him or her to cease to be eligible for coverage under another employer’s plan; or
- Experiences a change in employment status that causes him or her to gain eligibility for coverage under another employer’s plan.

If you decide you would like to change your coverage under any of the following benefits, you must properly request the change no later than 30 days after the event and the change must be consistent with the change in employment status that your spouse, domestic partner or dependent experienced:

- **Medical, dental and voluntary vision plans:**
  - If the event adversely affects eligibility for coverage under your spouse’s, domestic partner’s or dependent’s plan, you may enroll yourself, your spouse or domestic partner and any other dependent who lost eligibility under that other plan.
  - You may drop coverage or decrease your election if you and/or your family members become covered under the medical, dental or voluntary vision plan of your spouse or domestic partner because of the change in employment status.
• **Flexible spending accounts:**
  – If the event adversely affects eligibility for yourself, your spouse, your child(ren) (under age 26) or anyone who qualifies as your dependent for tax purposes under another employer’s health plan, you may enroll or increase your election for health care FSAs.
  – If the event increases your eligible dependent care expenses, you may enroll or increase your election for dependent care FSAs, or decrease your election if your spouse is now available to provide care.
  – You may decrease your health care FSA election if you and/or your family members become covered under a health plan of your spouse, domestic partner or dependent because of a change in eligibility under that other employer’s plan.

• **Supplemental life insurance:** You may enroll, increase or decrease coverage. An increase in coverage may be subject to Statement of Health (or evidence of insurability) requirements.

• **Dependent life insurance:** You may enroll, increase or decrease coverage (if applicable) for your spouse or domestic partner or any other eligible new dependents.

• **AD&D insurance** (if applicable): You may enroll, increase or decrease coverage.

• **Short-term disability:** You may enroll or drop coverage.

**What If... You Have a Change in Residence**

**Step 1: Things to Consider**

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<tr>
<th>Think about this…</th>
<th>More details provided in…</th>
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</thead>
<tbody>
<tr>
<td><strong>Will you need to change doctors as a result of your move?</strong></td>
<td><strong>Benefits.jhu.edu</strong></td>
</tr>
<tr>
<td>Certain plans offer coverage in certain geographic areas.</td>
<td></td>
</tr>
<tr>
<td>Therefore, it will be important to find out which doctors participate in which plans; you should visit the Benefits website.</td>
<td></td>
</tr>
<tr>
<td><strong>Do you need help finding the right child care provider?</strong> The Office of Work, Life and Engagement provides resources and referrals for family services and care.</td>
<td><strong><a href="http://www.hopkinsworklife.org">www.hopkinsworklife.org</a></strong></td>
</tr>
<tr>
<td><strong>Will you be changing dependent care providers?</strong> If so, the cost of providing dependent care may also change. You should consider whether to change your dependent care FSA election.</td>
<td><strong>Flexible Spending Accounts</strong></td>
</tr>
</tbody>
</table>

**Step 2: Take Action**

A change in residence might result in a change in eligibility for certain plans. For example, medical plans available in one state or locale might not be available in another. If you decide you would like to change your coverage under any of the following benefits, you must enroll no later than 30 days after the event:

• **Medical, dental and voluntary vision plans:** If the event significantly affects eligibility for coverage, you may make an election change that corresponds with the event (such as switching to a different option or dropping coverage if no other coverage is available).

• **Flexible spending accounts:** A change to your election for dependent care FSAs is permitted if your dependent care expenses increase or significantly decrease as a result of the move.

• **Supplemental life insurance:** You may increase or decrease coverage. An increase in coverage may be subject to statement of health requirements.

• **Short-term disability:** You may enroll.
What If... You Experience a Change in Coverage or Cost

Step 1: Things to Consider

<table>
<thead>
<tr>
<th>Think about this…</th>
<th>More details provided in…</th>
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</thead>
<tbody>
<tr>
<td>Have you, your spouse, domestic partner or dependent become entitled to Medicare or Medicaid, or lost entitlement to any group health coverage sponsored by the government? You should consider what changes to make to your medical, dental, and voluntary vision coverage.</td>
<td>Medical and Dental</td>
</tr>
</tbody>
</table>

Step 2: Take Action

A change in available coverage or the costs associated with that coverage might result in the need for you to change your benefit plan options. Examples of these types of changes include:

- You, your spouse, domestic partner or dependent become entitled to or lose entitlement to Medicare, Medicaid, CHIP, or any group health coverage sponsored by a government entity;
- JHU adds a new coverage option or benefit plan, or eliminates a coverage option or plan;
- JHU adds or eliminates a qualified benefit;
- The cost of your spouse’s, domestic partner’s or dependent’s coverage increases significantly; or
- An existing benefit option is significantly improved.

If you believe you need to change benefit plans or coverage based on any of the above types of changes, first consult the Benefits Service Center. If you decide you would like to change your coverage under any of the following benefits, you must properly request the change no later than 30 days after the event. The following are examples of the types of changes that would be permitted because of these types of events:

- **Medical, dental and voluntary vision plans:**
  - If a benefit or coverage option is eliminated, or if a benefit or coverage option is added, you may make an election change that corresponds with the event (such as switch to a different option, elect a new benefit or drop coverage if similar coverage is unavailable).
  - If your spouse’s, domestic partner’s or dependent’s employer sponsors a cafeteria plan that provides for a different open enrollment period than the annual enrollment period that applies under JHU’s Plan, or if your spouse, domestic partner or dependent makes a midyear change that is permitted under his/her employer’s plan such as a change made because of a family status change or a change in the cost of coverage under the plan, you may change your elections under the JHU Plan to coordinate your elections with his/her elections such as dropping coverage to enroll in his/her plan or electing coverage for a spouse, domestic partner or dependent who dropped coverage under his/her plan.
  - If your spouse becomes entitled to Medicare, you may elect to drop coverage for your spouse under the medical plan.

- **Dependent care flexible spending accounts:** A change to your election for dependent care FSAs is permitted if the amount that you have to pay to your child care provider significantly increases or decreases (but not if the provider who increased or decreased the rates is a close relative of yours).

- **Supplemental life insurance:** You may switch to a different option or drop coverage if the coverage ceases or the cost of coverage significantly increases.

- **Dependent life insurance** (if applicable): You may switch to a different option or drop coverage if the coverage ceases or the cost of coverage significantly increases.
• **AD&D insurance** (if applicable): You may switch to a different option or drop coverage if the coverage ceases or the cost of coverage significantly increases.

### What If...You Die While Actively Employed

#### Step 1: Things to Consider

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<tr>
<th>Think about this…</th>
<th>More details provided in…</th>
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<tbody>
<tr>
<td><strong>What will happen to health care coverage for your spouse, domestic partner and dependents?</strong> Generally, the coverage that is in place for your dependents at the time you die will continue until the end of the month in which you die. Your spouse and dependents* will be given an opportunity to continue their health care coverage for up to 36 months after coverage ends (COBRA coverage). They will be required to pay 102% of the full cost of coverage on an after-tax basis.</td>
<td><strong>Medical</strong> and <strong>Dental</strong></td>
</tr>
<tr>
<td><strong>What happens to your health care and dependent care spending accounts?</strong> Until April 30 of the calendar year after the calendar year of your death, your dependents may submit claims for eligible expenses incurred through the date you died. In addition, your spouse or dependent children generally may elect to continue coverage under the health care spending account through the end of the calendar year of your death. See the COBRA Notice section of this Summary for details on COBRA elections under the health care spending account.</td>
<td><strong>Flexible Spending Accounts</strong></td>
</tr>
<tr>
<td><strong>Will my beneficiary receive life insurance benefits?</strong> Eligible beneficiaries may receive benefits for basic life insurance provided by JHU and for any supplemental life insurance you may have purchased.</td>
<td><strong>Life, AD&amp;D, and Business Travel Accident Insurance</strong></td>
</tr>
</tbody>
</table>

* Federal law does not recognize your domestic partner as a spouse and he or she is not recognized as a COBRA-qualified beneficiary. However, the JHU health plans voluntarily provide "COBRA-like" health care continuation rights to covered domestic partners and their covered dependent children under the same types of terms and conditions that apply to spouses and dependent children entitled to COBRA rights under federal law. These continuation rights are not automatically granted; contact the Plan Administrator if you have questions about the continuation rights voluntarily extended to these individuals.

#### Step 2: Take Action

As soon as possible after your death, your spouse or domestic partner or survivors should inform your direct supervisor of your death and call the Benefits Service Center. Your designated beneficiaries will be contacted, and any claims will be initiated with the insurance companies.

If your eligible survivors want to continue JHU health care coverage, they must return the form used to elect that coverage and pay the applicable premiums within the time periods described in the COBRA notification that is sent to eligible survivors shortly after the Benefits Service Center is notified of your death.
**For Other Information, Go To....**

<table>
<thead>
<tr>
<th>The Big Picture</th>
<th>For general information about JHU's benefits program and how the myChoices Program works</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical, Dental, Disability, Life, AD&amp;D, and Business Travel Accident Insurance, Flexible Spending Accounts</td>
<td>For details about your JHU benefits</td>
</tr>
<tr>
<td>Administrative Information</td>
<td>For important facts about plan administration and rights you may have under ERISA</td>
</tr>
</tbody>
</table>
Chapter 3 – Medical Benefits

**FAST FACTS**

- You have several options for medical coverage.
- All medical options cover prescription drugs.
- If you are faculty or staff, you may decline medical coverage only if you are covered under another plan.
- You have several levels of coverage to choose from: individual, adult and child(ren), 2 adults, or 2 adults and child(ren).

Medical benefits help you and your family stay healthy and manage your health conditions. All options provide specified benefit coverage for preventive, routine, and emergency medical treatments and services.

If you are a faculty or staff member, you generally have three options from which to choose:

- CareFirst BlueCross BlueShield medical plan (an indemnity plan);
- EHP Classic (a point-of-service plan); and
- Kaiser Permanente (a health maintenance organization).

*Please note that faculty and staff members have an additional option, the BlueChoice HMO. This option was closed to new faculty and staff effective January 1, 2010. Information on this closed plan is available in this chapter.*

If you are a bargaining unit member, you also have three options from which to choose:

- CareFirst BlueCross BlueShield medical plan (an indemnity plan);
- BlueChoice (a health maintenance organization); and
- Kaiser Permanente (a health maintenance organization).

If you are a limited-time employee, you have the option to enroll in a medical plan:

- CareFirst BlueCross BlueShield Plan III (an indemnity plan).

When you enroll in medical coverage, you also receive prescription drug benefits. Your out-of-pocket costs depend on which medical plan you choose.
Benefits At-A-Glance

The following chart describes some of the major differences among these options.

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Indemnity Plan CareFirst BlueCross BlueShield Medical</th>
<th>Point-of-Service Plan (POS) EHP Classic</th>
<th>Health Maintenance Organization (HMO) BlueChoice Kaiser Permanente</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice of provider</td>
<td>You see any provider; you generally pay less when you use network providers.</td>
<td>You see any provider; you generally pay less when you use network providers.</td>
<td>Provider must be part of HMO’s network (for non-emergency care).</td>
</tr>
<tr>
<td>PCP/referrals needed</td>
<td>No referrals needed.</td>
<td>No referrals needed.</td>
<td>Need a referral to see a specialist.</td>
</tr>
<tr>
<td>How out-of-pocket costs are paid</td>
<td>You pay an annual deductible, then the plan generally pays 80% of the allowed benefit for covered services each time you need care (except preventive care). Some covered services require copays.</td>
<td>Your cost will vary based on how you seek care. Some covered services require copays, some require coinsurance (20% in-network after the deductible, 30% out-of-network after the deductible).</td>
<td>No deductible; you pay copay, and then the plan pays the balance for covered services.</td>
</tr>
</tbody>
</table>

Eligibility

Eligibility for the plan is outlined in Chapter 1, “The Big Picture.”

Cost

Your cost for coverage depends on your salary, level of coverage and the medical option you select. Refer to the first chapter of this document, “The Big Picture,” for information on your benefit elections and how the cost of your medical options is handled under JHU’s myChoices Program.

Consider Your Choices

Take the time to carefully consider your medical options. Changes are limited to annual enrollment and qualifying events.

Your Medical Plan Options

The Johns Hopkins University group health plans offer faculty, staff and bargaining unit employees several medical options, so you can choose the one that best meets your needs. Each option offers preventive care services, plus different coverage levels for protection against the high cost of treating major illness and injury. Certain coverage limits apply under all options, as discussed in the description of each option.

CareFirst BlueCross BlueShield Medical — This plan provides traditional indemnity-type medical coverage. You pay less for care when you use a provider in JHU’s Preferred Physician Network. The list of
providers in the JHU Preferred Physician Network may be accessed at:
http://benefits.jhu.edu/documents/JHU_CareFirst_PP_Dir.xlsx. When you use a provider in this network for
most covered services, the coverage is 100% after you meet a deductible. If you use providers other than
those in JHU’s Preferred Physician Network, your coverage is 80% of the allowed benefit for most covered
services after you meet a deductible. (Certain other health care providers have also contracted with
CareFirst to limit the amount they may charge participants.) There are limits to the amount you have to pay
out of your pocket each year (your out-of-pocket maximum). Once you meet your out-of-pocket maximum,
the plan pays 100% of the remaining eligible expenses that year.

**EHP Classic Plan (faculty and staff only)** — This plan is a point-of-service plan, which provides broad
medical coverage and the flexibility to use any provider. You generally pay less when you use providers who
are part of the Johns Hopkins Employer Health Program (EHP) network. The EHP Classic Plan does not
require you to select a primary care physician (PCP). Under the EHP Classic Plan, care for most eligible
expenses provided by an EHP provider is covered at 80% of the reasonable and customary charge, after a
deductible. No referrals are needed. If you see an out-of-network provider, most covered services are paid
at 70% of the reasonable and customary charge, after a deductible.

**Kaiser Permanente Medical Plan and BlueChoice HMO Plans** — These plans are health maintenance
organizations (HMOs), which provide broad medical coverage that must be coordinated by your HMO’s
primary care physician (PCP). You are limited to using physicians and facilities that are part of your HMO’s
network of providers (except in an emergency). This means that unless you have a life threatening
emergency, or a sudden and serious condition that occurs outside the HMO’s network area, all health care
services must be coordinated and approved by your HMO’s primary care physician to be considered for
coverage. For routine care, services from non-HMO providers are not covered. There are limits to the
amount you have to pay out of your pocket each year (your out-of-pocket maximum). Once you meet your
out-of-pocket maximum, the plan pays 100% of the remaining eligible expenses for that year.

**Declining Medical Coverage**

If you are full-time faculty or staff, you may decline medical coverage only if you have coverage under
another group medical plan (such as coverage through your spouse’s or domestic partner’s employer). To
do so, you must complete and return a waiver form to verify you have group medical coverage. If you
decline coverage through JHU and later lose the coverage you have elsewhere, you have 30 days to enroll
in a JHU group health plan. You can enroll in the plan by making an election under JHU’s myChoices
Program. Read more information on making an election under “Qualifying Events” in Chapter 1, “The Big
Picture.”

**Your Health Care Spending Account**

If you participate in the health care spending account, you can use that account to be reimbursed with tax-
free dollars for eligible out-of-pocket health care costs not reimbursed by JHU medical options or other
medical coverage.

**Medical Necessity**

To be covered under any medical option, services and supplies must be medically necessary. Medical
necessity means that, among other requirements, your medical care must:

- Be necessary for the diagnosis, care or treatment of a condition;
- Be widely accepted among U.S. health care professionals as effective, appropriate and essential;
- Be based on the recognized standards of the health care specialty involved; and
- Not be provided solely for personal comfort or convenience.
The exact definition of “Medical Necessity” is determined by CareFirst BlueCross BlueShield, the HMO or EHP in accordance with the provisions of the insurance policy or health plan document.

In all cases, care must be provided, prescribed or approved by a legally qualified physician or practitioner who is practicing within the scope of his/her license and providing a covered service to be considered for coverage under the plan.

**What to Do in an Emergency**

In a medical emergency, at home or away from home, seek help immediately at the nearest hospital emergency room, urgent care facility, or doctor’s office.

The coverage of your costs will vary depending upon the plan you are enrolled in. Of course, you and your physician should make an independent determination about what care is appropriate for you, and you should not base this determination on whether the plan will or will not provide coverage for that care.

“Medical emergency” has different meanings, depending on the plan in which you participate. For further information about coverage, see “Emergency Services” under each plan’s description in this chapter.

Coverage is not provided if you use an emergency room (or other emergency facility) for care that is not considered a medical emergency. In case of an emergency, if you are admitted to the hospital, you (or someone on your behalf) must notify your HMO or EHP within 48 hours of the admission.

**Prescription Drug Benefits**

**Express Scripts**

Express Scripts administers prescription drug benefits for the CareFirst BlueCross BlueShield Medical, EHP Classic, BlueChoice HMO, and CareFirst BlueCross BlueShield Plan III medical plan options. Prescription drug benefits under the Kaiser Permanente HMO are provided directly by Kaiser.

Subject to all plan limits and provisions, including all limits and provisions in the Pharmacy Benefit Managers Agreement, the plan covers an approved list of prescription drugs (formulary). A formulary is a list of drugs reviewed and approved by an independent committee of physicians and pharmacists. The formulary includes drugs that are commonly prescribed, clinically useful and cost effective. Three categories of drugs make up the formulary:

- **Tier 1** drugs are typically the most common generic drugs found in the formulary. Generic drugs contain the same active ingredients as their brand-name equivalents. Your cost will be lowest with a prescription for a generic drug. If you are taking a medication that’s not on the preferred list, ask your doctor to consider prescribing a lower-cost generic or preferred brand-name drug.

- **Tier 2** drugs are brand name drugs that appear in the formulary. Formulary brand name drugs are generally higher cost drugs than Tier 1; thus, they have a higher copayment for you. If a generic version of a drug is not available, your provider will likely prescribe a formulary brand name drug.

- **Tier 3** drugs are non-formulary brand name drugs that do not appear in Tier 1 and Tier 2. These are generally new drugs as well as drugs that have a more cost-effective generic or brand equivalent on Tier 1 or Tier 2. Because they are non-formulary, they will be the most expensive prescription option for you because they have the highest copayment. If your doctor believes that there are special reasons you should continue using your current brand medicine, he or she can request a coverage review. Or, you can call Express Scripts Member Services to request a review of your coverage.

To determine if your prescription is on the formulary list, go to [www.Express-Scripts.com](http://www.Express-Scripts.com) or call 800-336-3862.
When you purchase your medication, the amount of your copayment will depend on which tier your drug falls under. Some medications are covered at 100% as required under the Affordable Care Act for preventive items and services. You may purchase your prescriptions either through a retail pharmacy or through the mail-order program.

- **Retail**: If you are faculty or staff, you will receive up to a 30-day supply of your medication when you purchase it through a participating retail pharmacy. If you are a bargaining unit employee, you will receive up to a 90-day supply of your medication when you purchase it through a participating retail pharmacy. Take your Express Scripts ID card to the pharmacy where you normally order your prescriptions; the pharmacy will fill your prescription for the prescribed medication. This is the right choice for prescription drugs you take on a short term basis, such as an antibiotic.

- **Mail-order program**: Mail-order pharmacy offers both convenience and cost savings to individuals taking maintenance prescription drugs. You’re encouraged (but not required) to use the mail-order program for maintenance medications. If you use the mail-order program, you will receive up to a 90-day supply of your medication and usually pay less than if you obtained a 90-day supply at a retail pharmacy. In addition, with the mail-order program, you have the convenience of direct delivery to your home. This is the right choice for medications you take on a regular basis, such as, medications used to treat an ongoing condition.

Go to [www.Express-Scripts.com](http://www.Express-Scripts.com) for more information about the mail-order program and to obtain the form to order medications. (If you are a first-time visitor to the website, please take a moment to register; have your member ID and a prescription number available.) You may also call 800-336-3862.

Prescription refills will not be covered before a predetermined percentage of the original supply of medication has been used.

There are limits to the amount you have to pay out of your pocket each year (your out-of-pocket maximum) for prescription drug expenses. Once you meet your out-of-pocket maximum, the plan pays 100% of the remaining eligible expenses for that year. You would still be responsible for paying for any uncovered expenses. Expenses incurred in one year cannot be applied towards meeting your out-of-pocket maximum in the next year. The out-of-pocket maximums are as follows:

<table>
<thead>
<tr>
<th>Annual out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
</tr>
<tr>
<td>1 Adult and Child(ren)</td>
</tr>
<tr>
<td>2 Adults</td>
</tr>
<tr>
<td>2 Adults and Child(ren)</td>
</tr>
</tbody>
</table>

**Mandatory Generics**

(Applies to all prescriptions under CareFirst BlueCross BlueShield Medical, EHP Classic, BlueChoice HMO, and CareFirst BlueCross BlueShield Plan III medical plan options beginning January 1, 2018)

Tier 1 or generic drugs are lower cost medications that are just as effective as brand-name drugs. You may pay more if you purchase a brand medicine when a generic-equivalent medicine is available. You will be responsible for the coinsurance plus the difference in cost between the brand and generic prescription. In addition, any difference in the cost between a brand medication and the generic-equivalent, if a generic is
available and appropriate (as determined by your physician), will not be counted towards your annual out-of-pocket maximum amount.

**Drug Quantity Management**

(Applies to all prescriptions under CareFirst BlueCross BlueShield Medical, EHP Classic, BlueChoice HMO, and CareFirst BlueCross BlueShield Plan III medical plan options beginning January 1, 2018)

To ensure that the most cost effective product strength is prescribed and to reduce waste, certain medications may be covered but with limits. For example, if only a certain amount of a medication is indicated based on a condition and if your treatment is outside of those recommendations, approval may be required by Express Scripts.

**Step Therapy**

(Applies to new prescriptions under CareFirst BlueCross BlueShield Medical, EHP Classic, BlueChoice HMO, and CareFirst BlueCross BlueShield Plan III medical plan options after January 1, 2018; current prescriptions are grandfathered while in continuous use)

Step therapy requires you to try lower cost medications first before using medications that cost more. If your medication requires step therapy, you will be obligated to try a “step one” medication before using a “step two” (or “step three”) medication. “Step one” medications are proven to be safe, effective and affordable and provide the same health benefits as more expensive medications at a lower cost to you.

**Prior Authorization**

(Applies to new prescriptions under CareFirst BlueCross BlueShield Medical, EHP Classic, BlueChoice HMO, and CareFirst BlueCross BlueShield Plan III medical plan options in certain drug categories after January 1, 2018; current prescriptions are grandfathered while in continuous use)

Some medications will require prior authorization or review and approval before the plan covers the cost. This review includes a review of rules for FDA-approved prescribing and safety information and clinical guidelines. This is to ensure that the medication you receive is safe and effective for your condition. Failure to obtain prior authorization may result in denial of the claim.

Prior authorization may be required for prescriptions that:

- Have potentially dangerous side effects,
- Are harmful when combined with other drugs,
- Are often misused,
- Are prescribed when less expensive drugs are as effective,
- Are specialty medications that are meant to treat very specific diseases and require characteristics that help assess whether the drug will be effective for you.

To find out whether a medication requires a coverage review, log in to express-scripts.com. Select “Price a medication” under “Manage Prescriptions”, and search for your medication. On the results page, select ‘View coverage notes” to see coverage details.
If your medication needs approval, either you or your pharmacist will need to notify your doctor. Your doctor will then need to switch your medication to meet Express Scripts recommendations or you may contact them at 1-888-406-1213 to begin the approval process.

Kaiser Permanente

Kaiser Permanente administers prescription drug benefits under the Kaiser Permanente HMO medical plan option. Under the plan, prescription drug benefits are provided as follows:

- You may purchase your prescriptions either on a retail basis or through the mail-order program.
  - **Retail:** You will receive a 30-day supply of your medication when you purchase it retail. You’re encouraged (but not required) to use the mail-order program for maintenance medications.
  - **Mail Order Program:** With the mail-order program, you will receive a 90-day supply of your medication. You also have the convenience of direct delivery to your home. There are a variety of ways to order a prescription by mail:
    - Call **800-733-6345**. You can speak to a pharmacy mail-order customer service representative who can help explain the program and get a prescription transferred from a pharmacy to Kaiser’s Mail Order Program.
    - Call EZ Refill at **800-700-1479** for an automated prescription refill service. Follow the menu selections to re-order a prescription already on file with the Kaiser Mail Order Program.
    - Order by mail. Send the completed EZ Refill prescription form (available at any Kaiser Medical Center) to:
      Kaiser Permanente, Pharmacy
      P.O. Box 2368
      Reston, VA 20195
      (A refill prescription normally will be sent out within five days upon receipt of the order.)
    - Order by fax. Complete the EZ Refill prescription form available at any Kaiser Medical Center and fax it to **703-709-1688**.
    - Order by email. Members can visit the website at [www.kp.org](http://www.kp.org) and order refills.

- When you purchase your medication, the amount of your copayment will depend on whether your prescription is generic or brand, or non-formulary and whether you are purchasing it from a Kaiser pharmacy or a community pharmacy.
- Prescription refills will not be covered before a predetermined percentage of the original supply of medication has been used.
- There are limits to the amount you have to pay out of your pocket each year (your out-of-pocket maximum). This maximum includes your copays for prescription drugs. Once you meet your out-of-pocket maximum, the plan pays 100% of the remaining eligible expenses for that year.

**Notice of Privacy Practices**

The health plan options offered under the plans will comply with the applicable health information privacy requirements of federal regulations issued by the Department of Health and Human Services.

The plan’s privacy policies are described in more detail in the plan’s Notice of Health Information Privacy Practices or Privacy Notice. Covered employees receive the plan’s Privacy Notice automatically. In addition, a copy of the plan’s current Privacy Notice is always available upon request. Please contact the Plan Administrator at the address indicated later in this Handbook if you would like to request a copy of the Notice or if you have questions about the plan’s privacy policies. For any insured coverage, the insurance issuer is
responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer’s Privacy Notice.

Hospital Stay Following Childbirth

Under federal law, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

In certain cases, you may be entitled to other protections under state law. For example, if your medical benefits are provided under an insurance policy issued in Maryland, the following applies under state law:

Any health insurance company insuring health benefits under the plan generally will provide coverage for the cost of inpatient hospitalization services for a mother and newborn child for a minimum of 48 hours after an uncomplicated vaginal delivery; and 96 hours after an uncomplicated cesarean section. However, a mother may request a shorter length of stay if she decides, in consultation with the mother’s attending provider that less time is needed for recovery. For a mother and newborn child who have a shorter hospital stay than described above, the insurance company will provide coverage for one home visit scheduled to occur within 24 hours after hospital discharge; and an additional home visit if prescribed by the attending provider. For a mother and newborn child who remain in the hospital for at least the 48 hours or 96 hours (whichever applies) described above, the insurance company will provide coverage for a home visit if prescribed by the attending provider.

Breast Reconstruction Following Mastectomy

Federal law requires health plans that provide mastectomy benefits to also provide coverage for certain kinds of reconstructive surgery following a mastectomy.

Under the law, if you or a covered dependent are receiving benefits under the plan in connection with a mastectomy and elect breast reconstruction in consultation with the attending physician, coverage will be provided for:

• Reconstruction of the breast on which the mastectomy was performed;
• Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
• Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

These reconstructive benefits are subject to any applicable deductible and coinsurance provisions like other medical and surgical benefits covered under the plan.

Approved Clinical Trial Benefits

The Plan will not deny coverage for otherwise eligible benefits based on participation in an Approved Clinical Trial or deny, limit or impose additional conditions on the coverage of routine costs for items and services furnished in connection with participation in the approved clinical trial; and will not discriminate based on participation in the clinical trial.
Routine costs include all items and services that would otherwise be covered under the Plan but does not include:

- The investigational item, device, or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If one or more in-network providers is participating in the Approved Clinical Trial, the Plan may require that you or your covered dependent participate in the trial through an in-network provider. The Plan will not require you or your covered dependent to participate through an in-network health care provider however an out-of-network provider may charge for balances above the allowed benefit. The Plan will not impose any in-network requirement if that requirement would prevent you or your covered dependent who is participating in an Approved Clinical Trial conducted outside the State where you reside from qualifying for the Approved Clinical Trial benefits. The Plan is not required to provide benefits for routine patient care services provided outside of the Plan’s provider network unless out-of-network benefits are otherwise provided under the Plan.

You and/or your covered dependent(s) are eligible, under the trial protocol, to participate in an Approved Clinical Trial for treatment of cancer or another life-threatening disease or condition for which participation in the program is appropriate based on the conclusion of referring in-network health care professional or medical and scientific information provided.

An Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is:

- Federally funded. The study or investigation is approved or funded by one or more of the following: The National Institutes of Health, The Centers for Disease Control and Prevention, The Agency for Health Care Research and Quality, The Centers for Medicare & Medicaid Services, a cooperative group or center of any of the previously described entities or the Department of Defense or the Department of Veterans Affairs.
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- The Department of Veterans Affairs, the Department of Defense or the Department of Energy if the following conditions are met:
  - The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration
  - The study or investigation is a drug trial that is exempt from having such an investigational new drug application. The study or investigation has been reviewed and approved through a system of peer review that the Secretary of the Department of Health and Human Services determines is comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

**Infertility Benefits**

Artificial Insemination (AI)/ Intrauterine Insemination (IUI) and In Vitro Fertilization (IVF) services are covered subject to the following limitations;

- Benefits for outpatient Artificial Insemination (AI) / Intrauterine Insemination (IUI) procedures and In Vitro Fertilization (IVF) procedures are available to you, your spouse or domestic partner. Artificial Insemination (AI) / Intrauterine Insemination (IUI) benefits are available when you, your spouse or domestic partner have a proven medical diagnosis of infertility or as part of a physician recommended.
treatment. The cost of donor sperm will be covered by the plan if the sperm is not viable and is recommended as part of the treatment plan. Benefits are not payable for surrogate motherhood or the freezing, storing and/or thawing of donor sperm. An approved treatment plan is required and the benefit is limited to 6 attempts per live birth.

- **In Vitro Fertilization (IVF) benefits are available for outpatient expenses arising from IVF procedures that are pre-approved by the plan and performed at medical facilities that confirm to The American College of Obstetricians and Gynecologists guidelines for IVF clinics or The American Fertility Society minimal standards for programs of IVF.**

- **Benefits are available when you, your spouse or domestic partner have a proven medical diagnosis of infertility associated with any medical conditions including: endometriosis, exposure in utero to diethylstilbestrol (DES), blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy), abnormal male factors, including oligospermia, contributing to the infertility or it must be part of a physician recommended treatment plan.**

- **Benefits are also available when you have been unsuccessful through AI/IUI if the above conditions do not exist; Donor sperm and donor oocytes will be covered if the sperm or egg are not viable and recommended as part of the treatment plan. Benefits are not payable for the purpose of surrogate motherhood or for the freezing, storing or thawing of sperm/eggs. The freezing and thawing of embryos (not storage) is covered. An approved treatment plan is required and the benefit is limited to 3 attempts per live birth and/or $100,000 per lifetime.**

Covered infertility services include:

- All medical and surgical infertility services including Artificial Insemination.

- The In Vitro Fertilization services and/or Gamete Intra Fallopian Transfer (GIFT) and/or Zygote Intra Fallopian Transfer (ZIFT) procedures including:
  - Diagnostic imaging including ultrasonographic and related methods of follicular evaluation;
  - Pathology and laboratory services such as blood chemistries, hormonal assays, ova and sperm processing prior to fertilization,
  - Fertilization and culture of fertilized ova,
  - Examination of the products of conception,
  - Surgical services including ova harvesting and transfer,
  - Laparascopy and the GIFT/ZIFT procedure,
  - Infertility drugs; and
  - Medical visits for evaluation, embryo implantation and follow-up care.

**Transgender Services**

CareFirst BlueCross BlueShield and EHP provide coverage based on medical necessity for inpatient and outpatient services for you and/or your dependents 18 years of age and older for gender reassignment treatment, including any resulting complications. Coverage is provided to those who have a diagnosis of gender dysphoria (GD) made by a licensed psychiatrist, psychologist or social worker. Cross-gender hormone therapy is covered for those at least 18 years of age, having the capacity to make fully informed decisions, without medical contraindications for taking the medication, diagnosed with GD by two qualified health professionals and the completion of three months of counseling prior to administration of the treatment.

Surgical covered services include; female to male reassignment; initial mastectomy/breast reduction, hysterectomy, salpingo-oophorectomy, colpectomy vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, phalloplasty, placement of testicular prostheses, and male to female reassignment; orchietomy, penectomy, vaginoplasty, clitoroplasty, labiaplasty and colovaginoplasty.
Benefits are determined in accordance with the otherwise applicable provisions of the plan based on the treatment being provided. Procedures that are determined to be cosmetic are not covered under the plan.

Under Kaiser Permanente, you and your covered dependents are eligible for transgender services based on medical necessity.

**Qualified Medical Child Support Orders**

Federal law requires group health plans to honor Qualified Medical Child Support Orders (QMCSOs). In general, QMCSOs are orders under state law (including a court approved settlement agreement or agency orders that have the force and effect of law under applicable state law) requiring a parent to provide health care support to a child—for example, in case of separation or divorce. Upon receipt of such an order that the Plan Administrator determines is qualified under ERISA and applicable state law, the plan will comply with the requirements of the QMCSO. A description of the procedures governing QMCSOs is available, without charge, from the Benefits Service Center.

**When Coverage Ends**

Your coverage under a medical plan generally will end on the earliest of the following dates:

- The end of the month in which your employment terminates or in which you cease to be an eligible employee for any other reason (such as because of a decrease in the number of hours worked or a transfer to an ineligible employee class);
- If you fail to make a required contribution for coverage, the last day for which you have paid for coverage;
- The date you report for active duty as a member of the armed forces of any country, unless you qualify to continue coverage under the JHU Military Leave Policy or applicable law; or
- The date the medical plan is discontinued.

Medical coverage for a dependent generally will end on the earliest of the following dates:

- The date that your medical coverage under the plan ends;
- For a dependent child who does not qualify for extended coverage based on a disability, the last day of the year in which he/she reaches age 26;
- The effective date of your election to drop dependent coverage;
- If you fail to make a required contribution for coverage for your dependent, the last day for which you have paid for coverage;
- The date on which your dependent (other than a child who is under age 26) enters active duty military service with the armed forces of any country;
- The date the plan ceases to provide coverage for dependents; or
- The date the medical plan is discontinued.

Coverage under the plan may also be terminated for any individual (or any employee or dependent covered under the same family coverage as that individual) who engages in fraud or who makes a material misrepresentation of fact relating to the coverage. For example, if someone knowingly files a claim for benefits for medical services or supplies that were not actually provided, that would be considered fraud and would lead to termination of coverage. An example of a material misrepresentation of fact would include an employee signing an enrollment form indicating that an individual is eligible for coverage as a dependent at a time when the employee knows that the individual does not qualify as the employee’s dependent. In such cases, coverage may be terminated retroactively, if appropriate, based on the details.
For medical coverage, a retroactive termination of coverage may occur in only two situations. First, as indicated above, if you fail to make any required contribution toward the cost of coverage by the applicable deadline, coverage would be terminated retroactive to the end of the period for which the required contributions were made. A retroactive termination also may occur if you or your dependent (or any person seeking coverage for you or your dependent) engages in fraud with respect to the plan, or makes an intentional misrepresentation of a material fact. In that case, the plan will provide at least 30 days advance written notice to any person who will be affected by the retroactive termination of coverage.

If your coverage terminates under certain conditions, you may have the right to elect continuation coverage for certain benefits offered under the plan. See the “Continuing Coverage under COBRA” section of this chapter for more details.

Also, if you take a leave of absence because of military service and your health coverage (for you and any covered family members) would otherwise terminate, you may elect to continue coverage under the plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You will be required to pay for such coverage in an amount determined under USERRA. (If your leave is for a period of 30 days or less, you will be required to pay only the amount that active employees pay for similar coverage.) This continuation coverage is basically identical to the continuation coverage described in the COBRA notice section of this summary and it may end for any of the reasons that COBRA continuation coverage would end, except that the maximum coverage period is different and the special COBRA coverage limits that apply to health care flexible spending accounts do not apply to USERRA continuation coverage under a health FSA. Specifically, note that USERRA continuation coverage will end no later than the last day of the month that includes the first of the following days: (1) the date coverage would terminate under the plan’s normal termination provisions for a reason other than your military service; (2) the last day of the 24-month period beginning on the date your military leave of absence begins; or (3) the day after the date on which you fail to apply for or return to a position of employment with the employer. Please contact the employer if you have questions about coverage during periods of military service.

**Subrogation**

As a condition to receiving benefits under the plan, you and those covered through you agree to transfer to the plan your or their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, as a condition to receiving benefits under the plan, if you or anyone covered through you receives any recovery, by way of judgment, settlement or otherwise, from another person or entity, the recipient agrees to reimburse the plan, in first priority, for any benefits paid by it (i.e., the plan will be first reimbursed fully, to the extent of any and all benefits paid by it, from any amounts received, with the balance, if any, retained by the covered person).

The obligation to reimburse the plan, in full, in first priority, exists regardless of whether the judgment or settlement or other arrangement specifically designates the recovery, or any portion, as including medical, disability or other expenses. Also, the obligation to reimburse the plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed by you or the person covered through you. The plan’s rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds you or the person covered through you receive or are entitled to receive from the third party, any liability or other insurance covering the third party, the covered person’s own uninsured motorist insurance or underinsured motorist insurance, any Medical, Disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of you or the person covered through you.

The plan may enforce its reimbursement or subrogation rights by requiring you or the person covered through you to assert a claim to any of the foregoing coverage to which you or the person covered through you may be entitled. The plan will not pay attorney fees or costs associated with a covered person’s claim.
without prior express written authorization by the plan. The plan will not be subject to any “make whole” or other similar subrogation rules.

You and any person covered through you are obligated to cooperate with the plan and its agents to protect the plan’s subrogation rights. Cooperation includes providing the plan or its agents with any relevant information requested, signing and delivering any documents the plan or its agents reasonably request, obtaining the written consent of the plan or its agents before releasing any party from liability, taking actions as the plan or its agents reasonably request to assist the plan in making a full recovery, and taking no action that may prejudice the plan’s rights.

If you or a person covered through you enters into litigation or settlement negotiations regarding the obligations of the other parties, you and the person covered through you must not prejudice the plan’s subrogation rights in any way. You and persons covered through you will not be eligible to receive any benefits in a subrogation situation unless you and they satisfy the requirements described above.

**Overpayment**

If you or anyone receiving coverage through you receives a benefit payment that exceeds the amount the recipient had a right to receive under the plan, the plan has the right to require that the overpayment be returned or to reduce any future benefit payments by the amount of the overpayment.

**Enrolling In Medical Coverage Through the Health Insurance Exchanges**

You should be aware that you generally will have a “special enrollment” opportunity under federal law to enroll in health coverage offered through the health insurance exchanges that were created in 2014 by the Federal Affordable Care Act. Note that if you do not enroll during your 60-day special enrollment period that begins after you lose your coverage under the university’s coverage, you generally must wait until the exchange’s next annual open enrollment period to enroll. Depending on your income, you also may be eligible for a premium subsidy to help you pay for coverage you elect through a state or federal exchange. Information about coverage options, premium subsidies and enrollment opportunities is available online at [https://www.healthcare.gov/](https://www.healthcare.gov/) or at state exchange sites (such as [http://www.marylandhealthconnection.gov/](http://www.marylandhealthconnection.gov/) for Maryland residents).

**Coordination of Benefits**

**When You Have Other Coverage**

The plan, like many other employer-sponsored plans, has a coordination of benefits feature. It prevents duplication of payment when you or your dependents have coverage under another group medical or dental plan, such as a spouse’s or domestic partner’s plan at work. What this means is that, if benefits are payable under another plan, your benefit from the plan may be reduced by the amount payable from the other plan.

When a medical or dental claim is made, benefits are coordinated as follows:

- The primary plan pays benefits first, without regard to any other plan; then
- The secondary plan pays any benefits covered by the secondary plan that are not covered by the primary plan.

If a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an eligible expense and a benefit paid. No plan pays more than it would without the coordination provision.
Here’s how coordination of benefits works:

- The plan that is primarily responsible for a person’s expenses — the plan that pays benefits first — is considered primary coverage for that person:
  - If the other plan doesn’t have a coordination of benefits provision, it is primary;
  - If the other plan has a coordination of benefits provision:
    - **For you**: This plan is your primary coverage;
    - **For your covered spouse or domestic partner**: The plan provided by his/her employer is primary;
    - **For your covered children or your covered domestic partner’s children**: The birthday rule determines which plan is primary. The plan covering the children through your spouse/domestic partner whose birthday falls earlier in the year is primary for the children. If you and your spouse/domestic partner have the same birthday, the plan covering the children through you or your spouse/domestic partner for the longer period of time is primary. If the other plan doesn’t have the birthday rule, but instead has a rule based on gender, the father’s plan is primary. If you’re divorced or legally separated, different rules may apply (see "In case of divorce or legal separation" which follows).

This plan will pay the lesser of:

- Its regular benefit in full (where it is primary); or
- Its regular benefit reduced by the benefits payable by any other plans (where it is secondary).

To figure the amount payable when this plan is secondary, subtract B from A, as shown below:

\[
A - B = 100\% \text{ of “allowable expenses” incurred by the person for whom the claim is made} - \text{Benefits payable by the “other plans”}
\]

**In case of divorce or legal separation or any other case where a covered child’s parents are not living as a couple**, the child’s primary plan is determined in the following order:

- The plan covering the parent who has financial responsibility for medical expenses under a court decree is primary;
- If there is no court decree, then:
  - First, the plan of the parent with legal custody of the child;
  - Then, the plan of the new spouse or domestic partner (if any) of the parent with legal custody of the child; and then
  - The plan of the natural parent without custody of the child.

If there is a court decree which provides that parents share joint custody of a covered child, without stating that one of the parents is responsible for health care expenses of the child, then the birthday rule determines which plan (JHU’s or the other parent’s) is primary. The plan covering the parent whose birthday falls earlier in the year is primary. If you and the child’s other parent have the same birthday, the plan covering you or the other parent for the longer period of time is primary.
Coordination of Benefits with Medicare

If you are eligible for Medicare and you continue to work for JHU as an eligible employee after age 65, you may continue your medical coverage under this plan. In that case, your Medicare coverage would be secondary and your medical coverage under this plan would be primary.

In general, this plan would be primary and pay benefits first for:

- Eligible employees age 65 and above with current employment status and spouses age 65 and above who participate in this plan on the basis of the employee’s current employment status;
- Social Security disabled individuals who are covered by this plan on the basis of current employment status (their own or a family member’s current employment status) and who are entitled to Medicare benefits based on disability (e.g., an employee’s disabled spouse or child); and
- For the first 30 months of Medicare entitlement, for certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD), regardless of the reason for the employer coverage.

Medicare becomes primary coverage if you are enrolled in Medicare and you decline medical coverage under this plan.

If you are on disability, and you are receiving Social Security disability benefits, you generally will become eligible for Medicare after 24 months. Once you become eligible for Medicare, if you are not an active employee of JHU but you are still covered under JHU’s plan, benefits under JHU’s plan will be treated as secondary to Medicare. This is true even if you do not actually enroll in Medicare, so you should enroll in both Medicare Part A and Medicare Part B as soon as you become eligible.

If you have questions about how your coverage coordinates with Medicare, contact the Benefits Service Center.

Filing Claims

The following is general information about filing medical and dental claims under the JHU medical options, dental options and claims for prescription drugs filled at non-participating pharmacies. Detailed information can be found in the “Administrative Information” section. Please note that generally is no need to file claims forms if you are covered under the HMO plans.

Be sure to file your claims promptly. The plan will not pay claims that are filed after the normal filing deadline, unless the charges relate to a previous claim already on file; periods during which you are legally incapacitated do not count towards this time limit.

To file a claim for benefits:

- Obtain a claim form. You must obtain a claim form for yourself and your eligible dependents from your carrier;
- Complete the form and keep a copy for yourself;
- If you paid the provider, request that reimbursement be sent to you or, if your provider is willing to accept payment directly from the carrier, simply sign the section on the form authorizing payment to the provider; and
- Mail the form and all required documentation to the address listed on the form. In some cases, you may be asked to provide additional diagnostic information during the claim review process.
After your claim has been submitted, you will receive an Explanation of Benefits (EOB) that describes what benefits the plan paid and, if applicable, what expenses were not covered. A check will be attached to the EOB unless you’ve assigned benefits to your provider.

If your claim is denied, you may request in writing that your claim be reconsidered. Read more about denied claims in the “Administrative Information” section.

Plan Descriptions

The different health plans offered through CareFirst, EHP and Kaiser are individually summarized below. You should keep in mind that these descriptions are intended to be a summary only. The official plan documents and contracts (including CareFirst “Evidence of Coverage”) contain full details of the legal provisions of each plan. In case of a conflict between the official plan documents, the summaries provided here in the Summary Plan Description, any other written materials, or any oral statements made to you concerning your benefits, the official plan documents will govern. You may ask the Benefits Service Center for plan documents for a complete list of covered services and exclusions.

CareFirst BlueCross BlueShield Medical

This plan provides traditional indemnity-type medical coverage, which means you pay your deductible first, and then you pay a portion of the cost (your coinsurance amount) each time you use medical services. You generally pay less for care when you use a provider in an approved network. If you use a provider in the JHU Preferred Physician Network, for most covered services, the coverage is 100% after you meet a deductible. The list of providers in the JHU Preferred Physician Network may be accessed here: [http://benefits.jhu.edu/documents/JHU_CareFirst_PP_Dir.xlsx](http://benefits.jhu.edu/documents/JHU_CareFirst_PP_Dir.xlsx). If you use a provider who is not a member of the JHU Preferred Physician Network, the plan pays 80% of the allowed benefit for most covered services, after you meet a deductible. There are limits to the amount you have to pay out of your pocket each year (your out-of-pocket maximum). Once you meet your out-of-pocket maximum, the plan pays 100% of the remaining eligible expense for that year. For preventive services, your coverage is 100% before the deductible.

Please note: Certain health care providers have contracted with CareFirst to limit the amount they may charge participants. The amount these providers charge is, in effect, "discounted." If you use a provider who is not a member of the JHU Preferred Physician Network but who has contracted with CareFirst, your coverage is still 80%, but the portion you pay (20% of the allowable charges) will generally be less than what you would pay for a provider without the same relationship with CareFirst because you are paying 20% of a "discounted" charge.

Here’s How This Plan Works

- You obtain medical care from the provider (such as a doctor or hospital) of your choice. The provider charges a fee for each medical service. If the service is a covered service, your payment will depend on the provider you choose. Providers in the JHU Preferred Physician Network normally will require less payment from you than those in the CareFirst BCBS PPO Network (sometimes there is no payment at all).
- The plan generally pays benefits after you pay your annual deductible (except for preventive services, which do not require a deductible). You will pay a percentage of allowed benefits for covered services.
- When your share of covered expenses in a calendar year reaches your out-of-pocket maximum, the plan pays the full charges of remaining covered expenses for that year, subject to plan limits.
- You or your provider files a claim for reimbursement of covered expenses.
Allowed Benefits

An allowed benefit is the maximum the plan will pay for a covered service. Under the CareFirst BlueCross BlueShield Medical plan, for physician and non-facility services, the allowed benefit is the amount the plan has agreed to pay to providers who contract with the plan’s provider network to be paid directly for covered services. For health care facilities, the allowed charge is the rate approved by the Health Services Cost Review Commission. For facilities over which the Health Services Cost Review Commission does not have authority, the allowed charge is the amount agreed upon by the facility and the plan.

If you use a provider who is not a participant in one of the preferred provider networks, your provider may bill you (or your covered dependent) for the difference (or balance) of charges above the amount the plan has set as an allowed benefit. For example, let’s say you saw a specialist for outpatient care. If we assume your deductible has already been met, your plan will pay for 80% of the allowed benefit for your visit; you will be responsible for the 20% of the allowed benefit of your visit. Your provider charged you $250 for the visit, but the allowed benefit set by the plan is $200. You will be responsible for a total charge of $90:

| A. Charge by specialist | $250 |
| B. Allowed benefit for comparable service | $200 |
| C. Your portion (20%) of allowed benefit | $40 |
| D. Balance billing (amount charged by specialist over the allowed benefit) | $250 minus $200 |
| E. Your total cost: your portion of allowed benefit plus balance billing (line C. plus line D.) | $90 |

Your Deductible

You must pay an amount each calendar year before the plan begins to pay benefits for most covered services. This amount is called the deductible. Once you reach your annual deductible, the plan pays a percentage of the allowed benefit, subject to option limits, for your remaining covered expenses in that year. A new deductible applies each calendar year but any eligible expenses for covered services incurred in the last three months of the calendar year and applied to the deductible will also be applied to the next calendar year’s deductible.

The deductible amounts for the CareFirst BlueCross BlueShield Medical are as follows:

<table>
<thead>
<tr>
<th>Annual Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
</tr>
<tr>
<td>1 Adult and Child(ren)</td>
</tr>
<tr>
<td>2 Adults</td>
</tr>
<tr>
<td>2 Adults and Child(ren)</td>
</tr>
</tbody>
</table>

The deductible does not apply to some services.

Understanding the Combined Deductible Limit

If you enroll for coverage for you and your spouse or domestic partner, you and your child, or your entire family, the limit listed above is the combined amount you and your covered dependents have to pay in deductibles each calendar year. Your family won’t have to pay more in deductibles for the year than the
combined amount that applies to your level of coverage, regardless of whether you or any covered family member reach the individual deductible.

**Expenses That Don’t Count Toward the Deductible**

Some expenses don’t count toward your deductible. These include amounts you pay:
- Above allowed charges;
- Above the coverage limit;
- For any uncovered expenses;
- For prescription drug benefits; and
- As copayment for inpatient admission.

**Your Out-of-Pocket Maximum**

Your out-of-pocket maximum is the annual limit you pay out of your own pocket for covered medical expenses, including your deductible, copayments and coinsurance.

Once you reach the out-of-pocket maximum, the plan pays the full cost (100%) of your remaining covered expenses for that year, up to allowed charges and subject to any benefit-specific coverage limits that may apply. You would still be responsible for paying any amounts in excess of the allowed charges, any amounts above a coverage limit that applies to a specific benefit, and any expenses for uncovered expenses. Expenses incurred in one year cannot be applied towards meeting your out-of-pocket maximum in the next year. The out-of-pocket maximums are as follows:
- For Faculty and Staff:

<table>
<thead>
<tr>
<th>Annual out-of-pocket maximum</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,000</td>
</tr>
<tr>
<td>1 Adult and Child(ren)</td>
<td>$4,000 \ for adult + one child; $6,000 \ for adult + two or more children</td>
</tr>
<tr>
<td>2 Adults</td>
<td>$4,000</td>
</tr>
<tr>
<td>2 Adults and Child(ren)</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

- For Bargaining Unit Employees:

<table>
<thead>
<tr>
<th>Annual out-of-pocket maximum</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$1,500</td>
</tr>
<tr>
<td>1 Adult and Child(ren)</td>
<td>$3,000 \ for adult + one child $4,500 \ for adult + two or more children</td>
</tr>
<tr>
<td>2 Adults</td>
<td>$3,000</td>
</tr>
<tr>
<td>2 Adults and Child(ren)</td>
<td>$4,500</td>
</tr>
</tbody>
</table>
Understanding the Combined Out-of-Pocket Maximum

If you enroll for coverage for you and any other family member, the limit listed above is the combined amount you and those covered through you have to pay out-of-pocket each calendar year for covered expenses. Your family won’t have to pay more out-of-pocket for the year than the combined limit that applies based on your level of coverage, up to allowed charges, whether or not you or any dependent reach the individual out-of-pocket maximum. Also, if any individual covered family member reaches his or her individual out-of-pocket maximum, the plan pays the full cost of your remaining covered expenses for that year for that individual family member, up to allowed charges and subject to any benefit-specific coverage limits that may apply. You would still be responsible for paying any amounts in excess of the allowed charges, any amounts above a coverage limit that applies to a specific benefit, and any expenses for uncovered expenses.

Expenses That Don’t Count Toward the Out-of-Pocket Maximum

Some expenses don’t count toward your individual or combined out-of-pocket maximum. These include amounts you pay:

• Above reasonable and customary charges;
• Above any plan limit;
• For any price difference between a brand name drug and a generic equivalent, if a generic is available and appropriate (as determined by your physician); and
• For any uncovered expenses.

Emergency Services

Emergency services are those health care services that are rendered after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possess an average knowledge of health and medicine to result in:

• Serious jeopardy to the mental or physical health of the individual;
• Danger of serious impairment of the individual’s bodily functions;
• Serious dysfunction of any of the individual’s bodily organs; or
• For a pregnant woman, serious jeopardy to the health of the fetus.

Examples might include, but are not limited to: heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings and other acute conditions as CareFirst determines.

For a definition of “medical emergency,” see “What to Do in an Emergency.”

Of course you and your physician should make an independent determination about what care is appropriate for you, and you should not base this determination on whether the plan will or will not provide coverage for that care.
What’s Covered by the CareFirst BlueCross BlueShield Medical

Preventive Care Services

Subject to all plan limits and provisions, services for preventive care are generally covered at 100%. These services include:

- Annual adult physical exams;
- Well-baby care for routine immunizations, screening tests or follow-up visits between birth and four weeks of age;
- Well-child care (through age 17);
- Immunizations (included in routine office visit);
- Mammograms (routine); coverage provided in accordance with the latest guidelines from the American Cancer Society;
- Diabetes screenings for adults with blood pressure levels above specified limits;
- Pneumonia vaccines for adults under age 65 with certain risk factors;
- Annual flu shots;
- Zoster vaccination (for shingles) for adults age 50 or older, and
- Biennial Adult Eye Exam through the Wilmer Eye Institute School of Medicine Provider Network (Call 410-955-5080 to schedule).

The following additional preventive care services for women are also covered at 100%:

- Annual well-woman office visit;
- All Food and Drug Administration (FDA)-approved contraceptive methods and sterilization procedures for women, in addition to patient education and counseling;
- Comprehensive lactation support and counseling for women;
- Human papillomavirus (HPV) testing for women ages 30 and older;
- HIV counseling and screening for women;
- Domestic violence screening and counseling for women;
- Counseling on sexually transmitted infections for women;
- Screening for gestational diabetes for women;
- Hepatitis B screenings for pregnant women; and
- Generic contraceptives (covered under Express Scripts).

Physician and Provider Services

Subject to all plan limits and provisions, physician services are generally covered at 80% of allowed benefit after the deductible (100% covered after the deductible if the service is offered by a provider in the JHU Preferred Physician Network which can be accessed here: http://benefits.jhu.edu/documents/JHU_CareFirst_PP_Dir.xlsx). These services include:

- Office visits;
- Medical and surgical services;
- Specialist care (inpatient);
- Second surgical opinion (no deductible); and
• Diagnostic services (outpatient).

Physician services provided in an outpatient hospital facility are covered at 80% of allowed benefit, after the deductible.

**Hospital Services**

Subject to all plan limits and provisions, hospital services are generally covered at 80% of allowed benefit, after the deductible and $250 hospital copay for faculty and staff, $150 for bargaining unit. These services include:

• Hospital service benefits (inpatient) for bed, board and routine nursing services in a semi-private, private room or a CareFirst special care unit. Related hospital service, medical supplies, equipment and private duty nursing services are covered;
• Outpatient surgery expenses for ambulatory surgery (facility is 100% covered);
• Emergency care (in-network) for a medical emergency, trauma or accident and emergency care follow up visits. A $100 facility copay is required; the facility copay is waived if admitted;
• Emergency care (out-of-network) for medical emergency, trauma or accident and emergency care follow up visits. A $100 facility copay is required; the faculty copay is waived if admitted; and
• Ambulance services for transport within local area or closest hospital from a place of accident to a hospital for a medical emergency. Transport is also provided between hospital and nursing health care facility or residence.

For purposes of determining hospital service coverage, see the definition of medical emergency in “What to Do in an Emergency.”

(Coverage amounts are limited as discussed elsewhere in this document.)

**Mental Health and Substance Abuse Services**

Mental health treatment is the treatment of an acute psychiatric disorder that can be expected to improve significantly through short-term medically necessary therapy. Substance abuse treatment is the effective treatment of chemical dependency on alcohol or drugs under the supervision of a provider that is certified by the Alcohol and Drug Abuse Administration of the Maryland Department of Health and Mental Hygiene. Subject to all plan limits and provisions, covered services for mental health and substance abuse include:

• Mental and nervous (inpatient) treatment in a hospital or treatment facility for bed, board and services in a semi-private and private room; hospital services, supplies and practitioner services are covered;
• Mental and nervous (outpatient) treatment provided in a facility approved by CareFirst for services or psychiatric day treatment benefits;
• Alcohol and drug addiction (inpatient) expenses for bed, board and services in a healthcare facility specializing in the rehabilitation of drug users and certified by the Alcohol and Drug Abuse Administration of the Maryland Department of Health and Mental Hygiene as a Residential Drug Free Treatment Rehabilitation Program; and
• Alcohol and drug addiction (outpatient) therapy services, counseling, psychological testing and other health care services prescribed for drug abuse rehabilitation rendered in a non-residential setting by a certified provider for an outpatient drug-free treatment program, outpatient chemotherapeutic treatment program and outpatient drug abuse counseling programs (crisis intervention programs and hotlines are not included).
Total Care and Cost Improvement

Total Care and Cost Improvement (TCCI) is an umbrella program for qualified Members, aimed at providing improved quality of care by coordination of services, across provider type, setting and time, for those at high risk or with multiple chronic conditions. TCCI encompasses programs including, but not limited to, Health Promotion, Wellness and Disease Management Services Program (WDM), Hospital Transition of Care Program (HTC), Complex Case Management Program (CCM), Chronic Care Coordination Program (CCC), Behavioral Health and Substance Use Disorder Program (BSD), Home-Based Services Program (HBS), Enhanced Monitoring Program (EMP).

The vehicle for all care coordination efforts in the TCCI program array is the care plan. There are three TCCI programs that employ care plans: CCC, CCM and BSD. Essential to care coordination and case management is the Member’s consent to the creation, maintenance and faithful adherence to a care plan. Qualified Members who are compliant in their care plans may be eligible for a cost share waiver (i.e. copays, coinsurance, and deductibles) for services rendered outside of a hospital setting and during their participation in the program.

To learn more about the TCCI programs, you may call CareFirst at 877-691-5856. You may also ask the Benefits Service Center for a copy of the Evidence of Coverage. Additional information can also be found on the CareFirst website here: https://individual.carefirst.com/carefirst-resources/provider/pdf/pcmh-program-description-guidelines.pdf.

Other Covered Services

Home health care for in-home care and services by or through a home health care agency within 72 hours after a hospital stay is an alternative to staying in a hospital. This care must follow the plan of treatment designated by the attending physician or a hospital medical director and be approved by CareFirst. Home health care is generally covered in full. There is a limit of 90 visits per year.

Durable Medical Equipment is defined as equipment prescribed and certified by health care practitioner for medical condition and therapeutic use. Air conditioners, humidifiers, exercise equipment, elevators and ramps are not included. Durable Medical Equipment is generally covered at 80% after the deductible.

Subject to all plan limits and provisions, the following other services are covered by the plan:

- Reproductive health care, including:
  - Pre- and post-natal care;
  - Family planning and fertility testing;
  - Artificial insemination (requires authorization by the plan); and
  - In-vitro fertilization
    Refer to the infertility section of this chapter for applicable services and limitations.
- Hearing exams and hearing aids for minor children (covered at 100% of allowed benefit every 36 months for one hearing aid for each hearing impaired ear);
- Physician-administered injectibles (self-injectibles are covered under the prescription plan); and
- Prescription drugs (drugs, biologicals and compounded prescriptions prescribed by a health care practitioner and pre-approved by CareFirst on an exception basis).
**What’s Not Covered**

The plan will not provide a benefit for:

- Any service, supply or item that is not medically necessary. Although a service may be listed as covered, benefits will be provided only if the service is medically necessary as determined by CareFirst;
- Any mental health and substance use disorder services not rendered by the mental health and substance use administrator;
- Services that are experimental/investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst;
- Services or supplies received at no charge to a Member in any federal hospital, or through any federal, state or local governmental agency or department, or not the legal obligation of the Member, or where the charge is made only to insured persons; this exclusion does not apply to:
  - Medicaid;
  - Benefits provided in any state, county, or municipal hospital in or out of the state of Maryland; or
  - Care received in a Veteran's hospital unless the care is rendered for a condition that is a result of a Member's military service.
- Routine, palliative, or cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet;
- Routine dental care such as services, supplies, or charges directly related to the care, restoration, removal or replacement of teeth, the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth;
- Cosmetic services (except for mastectomy-related services, services for cleft lip or cleft palate or both and approved transgender services);
- Treatment rendered by a health care provider who is the Member's parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or who resides in the Member’s home;
- All non-prescription drugs, medications, biologicals, and over-the-counter disposable supplies, routinely obtained and self-administered by the Member, except as described under "What’s Covered by the CareFirst BlueCross Blue Shield Medical;"
- Lifestyle improvements, including, but not limited to health education classes and self-help programs except as described under "What’s Covered by the CareFirst BlueCross Blue Shield Medical;"
- Fees or charges relating to: fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, use of passive or patient-activated exercise equipment;
- Treatment for weight reduction and obesity except for the surgical treatment of morbid obesity;
- Routine eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, except contact lenses when there is a diagnosis of Keratoconus;
- Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications;
- Services furnished as a result of a referral prohibited by law;
- Any service related to recreation activities. This includes, but is not limited to: sports, games, equestrian activities and athletic training, even though such services may be deemed to have therapeutic value;
- Non-medical, health care provider services, including, but not limited to:
- Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the health care provider or his/her staff; or
- Administrative fees charged by a health care provider to a Member to retain the health care provider’s medical practices services, e.g., “concierge fees” or boutique medical practice membership fees. Benefits under the Evidence of Coverage are limited to Covered Services rendered to a Member by a health care provider.

• Educational therapies intended to improve academic performance;
• Vocational rehabilitation, and employment counseling;
• Services related to an excluded service (even if those services or supplies would otherwise be covered services) except General Anesthesia & Associated Hospital or Ambulatory Surgical Facility Services for Dental Care;
• Separate billings for health care services or supplies furnished by an employee of a health care provider which are normally included in the health care provider’s charges and billed by them;
• Services that are non-medical in nature, including, but not limited to: personal hygiene, cosmetic and convenience items such as air conditioners, humidifiers, exercise equipment, elevators or ramps;
• Personal comfort items, even when used by a Member in an inpatient hospital setting, such as telephones, televisions, guest trays or laundry charges;
• Custodial, personal or domiciliary care that is provided to meet the activities of daily living, e.g., bathing, toileting and eating (care which may be provided by persons without professional medical skills or training);
• Self-care or self-help training designed to enable a Member to cope with a health problem or to modify behavior for improvement of general health unless otherwise stated;
• Travel, whether or not advised by a health care practitioner. Limited travel benefits related to an organ transplant or serious illness or injury may be covered;
• Services intended to increase the intelligence quotient (IQ) of Members with intellectual disability or to provide cure for primary developmental disabilities, if such services do not fall within generally accepted standards of medical care;
• Services for the purpose of controlling or overcoming delinquent, criminal or socially unacceptable behavior unless deemed Medically Necessary by CareFirst;
• Milieu care or in-vivo therapy: care given to change or control the environment, supervision to overcome or control socially unacceptable behavior, or supervised exposure of a phobic individual to the situation or environment to which an abnormal aversion is related;
• Dietary or nutritional counseling, diabetes equipment, supplies and self-management training;
• Tinnitus maskers, purchase, examination, or fitting of Hearing Aids except as described under “What’s Covered by the CareFirst BlueCross BlueShield Medical;”
• Except as specifically described in this document, services related to human reproduction including, but not limited to: maternity services for surrogate motherhood or surrogate uterine insemination, unless the surrogate mother is a Member;
• Blood products and whole blood when donated or replaced;
• Oral surgery, dentistry or dental processes unless otherwise stated;
• Treatment of temporomandibular joint disorders unless otherwise stated;
• Premarital exams;
• Services performed or prescribed by or under the direction of a person who is not a health care provider;
• Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice;
• Services provided through a dental or medical department of an employer; a mutual benefit association, a labor union, a trust or a similar entity;
• Services rendered or available under any Worker's Compensation or occupational disease, or employer's liability law, or any other similar law, even if a Member fails to claim benefits;
• Services provided or available through an agent of a school system in response to the requirements of the Individuals With Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students within the educational system, even when such services are of the nature that they are Covered Services when provided outside the educational domain;
• Illnesses resulting from an act of war;
• Charges used to satisfy a Member's dental care, prescription drug, or vision care benefits deductible, if applicable, or balances from any such programs;
• Legal services;
• Contraceptive devices and drugs, including insertion or removal and related examination unless otherwise stated or
• Hearing care except as otherwise stated.

Plan Description: EHP Classic Plan (Open to Faculty and Staff Members Only)

Johns Hopkins Employer Health Programs (EHP) offers a point-of-service (POS) plan that gives you the flexibility of using in-network or out-of-network providers. Your out-of-pocket costs are lower if you use providers who participate in the EHP network.

If you live or work outside the state of Maryland, have a child attending college out of state or travel out of state and need medical attention, EHP has an extended provider network through MultiPlan, which covers all 50 states. MultiPlan’s PHCS Healthy Directions offers a national network of doctors, hospitals and ancillary providers which can be found on the EHP website at https://www.ehp.org/plan-benefits/medical-care-network/. Please note that if you see a MultiPlan PHCS Healthy Directions provider within Maryland, that provider must also be part of the EHP provider network for your benefits to be “in-network.”

What are Reasonable and Customary (R&C) Charges?

Reasonable and customary charges are the usual fee charged by similar providers for the same services or supplies in the same geographic area. Johns Hopkins EHP determines what a reasonable and customary charge is. EHP network providers will not charge more than the reasonable and customary charge, but out-of-network providers can charge more.

Here’s How the EHP Classic Plan Works

Under the EHP Classic Plan, you don’t select a primary care physician. You have two options to seek care: choose a doctor in the Johns Hopkins EHP network or choose to receive care outside of the network. Both are explained in the following table.

A group of health care providers — doctors, hospitals and other providers in your area — have been selected to participate in the EHP network.* Network doctors include physicians from virtually all medical specialties. These providers have agreed to provide medical services and supplies at reduced rates in exchange for network membership.
| In-Network* | • This plan incorporates the cost-efficiencies that result from using a network of highly qualified health care professionals and facilities. To receive in-network benefits, you may go to any doctor in the Johns Hopkins EHP network, and the plan will pay benefits for covered services.  
• For most covered services, to receive benefits, you must first pay a calendar year deductible (see the “Your Deductible” section below for details). After meeting the calendar year deductible, in-network care is covered at 80%, and you pay the remaining 20% until you reach your annual out-of-pocket maximum. (Preventive care services are covered at 100%.)  
• Some services are available only under this option. |
| Out-of-Network | • At any time, you can decide to go out of the Johns Hopkins EHP network to any provider you choose.  
• Preventive care (i.e., adult physical exams and well-baby) is covered at 70% of reasonable and customary (R&C) charges, no deductible.  
• For all other covered services, to receive benefits you must first pay a calendar year deductible (see the “Your Deductible” section below for details). After meeting the calendar year deductible, out-of-network care is covered at 70% of reasonable and customary (R&C) charges, after you meet your deductible. You or your provider needs to file claims forms to be reimbursed.  
• When your share of covered expenses in a calendar year for out-of-network care (your coinsurance, including your deductible) reaches your out-of-pocket maximum, the option pays 100% of the R&C charges of your remaining covered expenses for that calendar year, subject to coverage limits. You must pay any amount in excess of R&C charges, and you must pay for uncovered expenses. |

*Note: MultiPlan PHCS Healthy Directions national network available if you live, work, travel or attend school outside of Maryland.

**Allowed Charges**

An allowed charge is the maximum the medical option will pay for a covered service. For EHP Classic Plan, allowed charges are based on the reasonable and customary (R&C) charges. R&C is the usual fee charged by similar providers for the same services or supplies in the same geographic area. Please note that charges for services that are determined to be not medically necessary will not be considered reasonable and customary.

**Care Management Program**

Before you can receive benefits for certain medical services and supplies under the EHP Classic Plan, you must have these services and supplies pre-certified and coordinated through the Johns Hopkins EHP Care Management Program. Your network doctor will initiate this pre-authorization process if you are in-network; you or your out-of-network doctor must initiate this pre-authorization process if you are out-of-network. If you do not obtain pre-authorization when required, coverage for benefits may be limited or denied entirely. The following services and supplies require pre-authorization through the Care Management Program:

• Durable Medical Equipment and medical supplies;
• Hearing aids for minor children every 36 months for one hearing aid for each hearing-impaired ear (the aid must be prescribed, fitted and dispensed by a licensed audiologist; replacement aids are available only once every three years);
• Home health care;
• Hospice care;
• Hospital stays;
• Infertility services;
• Nutritional counseling after the initial and one follow-up visit;
• Prosthetic devices and orthotics;
• Rehabilitation;
• Skilled nursing facility stays;
• Speech therapy;
• Surgery for morbid obesity;
• Surgical procedures (certain procedures only, as described on a list maintained by Johns Hopkins Employer Health Programs: in-network, your network doctor obtains this pre-authorization on your behalf; out-of-network, you are required to contact EHP Customer Service to see if a proposed surgical procedure is on this list, and if it is, it is your responsibility to obtain pre-authorization);
• Temporomandibular Joint Syndrome (TMJ) treatment;
• Transplant services; and
• Mental health and substance abuse (including hospital in-patient stays, in-patient residential, “partial hospitalization” day treatment programs and intensive outpatient care). Pre-authorization is required.

The Care Management Program is not intended to diagnose or treat your medical conditions or to guarantee benefits. Rather, the Care Management Program will assist in coordinating the medical care services you receive across the continuum of care.

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

**Out-of-Network Care**

When you obtain out-of-network care, the EHP Classic Plan works like traditional medical coverage. Additional provisions apply to out-of-network care that affect what you need to do and how much you pay, such as:
• Advance approval requirements for care in a hospital or special facility;
• Deductibles;
• Out-of-pocket maximums; and
• Filing claim forms.

**Your Deductible**

You and each covered dependent must pay an amount each calendar year before the EHP Classic Plan begins to pay benefits for most covered services. This amount is called the deductible.

Once you reach your annual deductible, the option pays a percentage of the reasonable and customary charges, subject to plan limits, for your remaining covered expenses in that year.
A new deductible applies each calendar year. The deductible amounts for the EHP Classic Plan are as follows:

<table>
<thead>
<tr>
<th></th>
<th>In-network care</th>
<th>Out-of-network care</th>
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</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>1 Adult and Child(ren)</td>
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<td></td>
<td>$500 for Adult + one child</td>
<td>$1,000 for Adult + one child</td>
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<td>$750 for Adult + two or more children</td>
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<tr>
<td>2 Adults</td>
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<td>2 Adults and Child(ren)</td>
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<td></td>
<td>$750</td>
<td>$1,500</td>
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</tbody>
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Understanding the Combined Deductible Limit

If you enroll for coverage for you and your spouse or domestic partner, you and your child, or your entire family, the limit listed above is the combined amount you and those covered through you have to pay in deductibles each calendar year. Your family won’t have to pay more in deductibles for the year than the family amount, whether or not you or any dependent reach the individual deductible.

Expenses That Don’t Count Toward the Deductible

Some expenses don’t count toward your deductible. These include amounts you pay:

- Above reasonable and customary charges;
- Above any coverage limit;
- For any penalties that apply when you fail to pre-certify certain services as required;
- For any uncovered expenses;
- For prescription drug benefits; or
- As copayments.

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the annual limit on the amount you pay out of your own pocket for covered medical expenses, including your deductible, copayment and coinsurance. The out-of-pocket maximum is calculated separately for in-network care and out-of-network care. The out-of-pocket maximums are as follows:

<table>
<thead>
<tr>
<th></th>
<th>In-network care</th>
<th>Out-of-network care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,000</td>
<td>$4,000</td>
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<tr>
<td>1 Adult and Child(ren)</td>
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<td></td>
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<tr>
<td></td>
<td>$4,000 for Adult + one child</td>
<td>$8,000 for Adult + one child</td>
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<tr>
<td></td>
<td>$6,000 for Adult + two or more children</td>
<td>$12,000 for Adult + two or more children</td>
</tr>
<tr>
<td>2 Adults</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
</tbody>
</table>
Once your expenses (including your deductibles) reach this amount for the calendar year, the option pays the full cost of your remaining covered expenses for that year, up to R&C charges and subject to coverage limits. You are responsible for any amounts in excess of R&C charges, in excess of coverage limits, and for uncovered expenses. A new out-of-pocket maximum applies to your share of covered expenses each year.

**Understanding the Combined Out-of-Pocket Maximum**

If you enroll for coverage for you and one or more eligible family members, the limit listed above is the combined amount you and your covered dependents have to pay out-of-pocket each calendar year for covered expenses. You won’t have to pay more out-of-pocket for eligible medical expenses for the year for expenses that count towards the out-of-pocket maximum than the amount that applies to your level of coverage regardless of whether you or any dependent reach the individual amount. However, you are responsible for any amounts that don’t count toward the out-of-pocket maximum.

**Expenses That Don’t Count Toward the Out-of-Pocket Maximum**

Some expenses don’t count toward your out-of-pocket maximum. These include amounts you pay (or amounts you are billed):

- Above reasonable and customary charges;
- Above any coverage limit;
- For any penalties that apply because you fail to pre-certify certain services as required;
- For any price difference between a brand name drug and a generic equivalent, if a generic is available and appropriate (as determined by your physician); and
- For any uncovered expenses.

**Emergency Services**

In a medical emergency, at home or away from home, seek help immediately at the nearest hospital emergency room, urgent care facility, or doctor’s office. The coverage of your costs will vary depending upon whether the provider is in-network or out-of-network. For a definition of “medical emergency,” see “What to Do in an Emergency.”

Coverage is not provided if you use an emergency room (or other emergency facility) for care that is not considered a medical emergency. Of course, you and your physician should make an independent determination about what care is appropriate for you, and should not base this determination on whether the plan will or will not provide coverage for that care.

In case of an emergency, if you are admitted to the hospital, you (or someone on your behalf) must notify Johns Hopkins EHP at 410-424-4450 or 800-261-2393 within 48 hours of the admission.

**What’s Covered by the EHP Classic Plan**

**Preventive Care Services**

Subject to all plan limits and provisions, services for preventive care are generally covered at 100% (with no deductible) for services provided in-network and 70% of reasonable and customary charges (no deductible) for services provided out-of-network. These services include:

- Annual adult physical exams;
• Prostate screenings;
• Routine gynecological visits, mammography screenings (based on the latest guidelines from the American Cancer Society), and routine PAP smears;
• Newborn care, including routine nursing care, services for babies born prematurely and preventive health care services;
• Well-child care through age 17;
• Immunizations (included in routine office benefit);
• Diabetes screenings for adults with blood pressure levels above specified limits;
• Pneumonia vaccines for adults under age 65 with certain risk factors;
• Annual flu shots; and
• Zoster vaccination (for shingles) for adults age 60 or older.

The following additional preventive care services for women are also covered at 100%, in-network (with no deductible) and 70% of reasonable and customary charges (no deductible) for services provided out of network. These services include:

• Annual well-woman office visit;
• All Food and Drug Administration (FDA)-approved contraceptive methods and sterilization procedures for women, in addition to patient education and counseling;
• Comprehensive lactation support and counseling for women;
• Human papillomavirus (HPV) testing for women ages 30 and older;
• HIV counseling and screening for women;
• Domestic violence screening and counseling for women;
• Counseling on sexually transmitted infections for women;
• Screening for gestational diabetes for women;
• Hepatitis B screenings for pregnant women; and
• Generic contraceptives (covered under Express Scripts).

**Physician and Provider Services**

Subject to all plan limits and provisions, inpatient physician services are generally covered at 80% after deductible for services provided in network and 70% after deductible for services provided out of network. These services include:

• Abortion (elective);
• Acupuncture (for anesthesia, pain control and therapeutic purposes provided by a licensed acupuncturist) limited to a calendar year maximum of $1,000;
• Allergy testing and treatment to determine the nature of allergies and desensitization treatment including test of treatment materials;
• Birthing facilities — eligible provided the physician in charge is acting within the scope of his/her license and the birthing facility is a freestanding licensed facility for childbirth which meets state licensing requirements;
• Casts and splints;
• Chiropractic care (out-of-network providers must be licensed and qualified to perform chiropractic services); services are covered for initial examination, X-rays, manipulation, misalignment or partial dislocation of or in the vertebral column, and correction by manual or mechanical means of nerve interference;
- Colorectal screening (covered at 100%);
- Consultation services by a specialist in the medical field for which the consultation relates (staff consultation required by the facility is not covered);
- Diagnostic medical procedures consisting of EKG or EEG, and other electronic diagnostic medical procedures;
- Diagnostic X-rays (including radiology, ultrasound, nuclear medicine, and magnetic resonance imaging, as well as laboratory services and pathology tests);
- Doctors' (including surgeons') fees for treatment of illness or injury;
- Doctors' fees and hospital charges for maternity care;
- Doctors' fees for office visits;
- Foot care for incision and drainage of infected tissues of the foot, removal of lesions, treatment of fractures and dislocations of bone in the foot;
- Foot orthotics that are an integral part of a leg brace and the cost is included in the orthotist's charge, or they are custom-molded and related to a specific medical diagnosis;
- Laboratory tests;
- Midwife delivery services, only if the state in which the services are performed has a licensing or certification process for midwifery, and the midwife is properly licensed at the time delivery is performed;
- Newborn care — necessary care and treatment of medically diagnosed congenital defects and birth abnormalities if the baby is eligible for enrollment and the newborn is enrolled within 30 days of birth;
- Nursing services (professional) by a registered nurse or licensed practical nurse who is not a close relative (spouse, domestic partner, child, grandchild, brother, sister, parent or grandparent of the patient or the patient's spouse or domestic partner) who resides in the Member's home;
- Surgical treatment for morbid obesity (if certain conditions are met; care must be pre-certified by the Care Management Program);
- Pre-admission tests made before an inpatient or outpatient surgery;
- Reconstructive surgery when due to accidental injury or illness (unless the plan would exclude coverage for the injury or illness for a reason other than it occurred before coverage began), correction of a congenital malformation of a child, or a mastectomy;
- Second surgical opinions for elective surgeries to determine medical necessity when provided by a board-certified specialist in the treatment of your particular medical condition, who is not associated professionally or financially with the physician who provided the first surgical opinion consultation; one additional consultation, as a third opinion, is eligible under this clause when the second opinion disagrees with the first (a second surgical/medical opinion consultation is required to be pre-certified through the Care Management Program);
- Surgical dressings and medical supplies ordered by an appropriate professional provider in connection with medical treatment (except self-administered supplies or convenience items);
- Surgical procedures (see further explanation below);
- Temporomandibular Joint Syndrome (TMJ) treatment and/or orthographic surgery, limited to physical therapy, surgery and orthodontic devices such as mouth guards and intraoral devices (excludes orthodontics and prosthetics);
- 3-D nipple tattoo of a reconstructed breast, only if the tattoo artist is recommended by the reconstructive surgery provider and possesses a license to provide tattoos (if a license is required);
- Vasectomies and tubal ligations;
- Biennial vision exam (in-network only, excludes contact lenses fitting fee);
- Rehabilitation services at a rehabilitation facility that is licensed to provide comprehensive rehabilitation services to patients recovering from an accident or an illness, and for evaluation and treatment of
individuals with physical inabilities with emphases on education and training. The program must be coordinated and provided by or under the supervision of physicians who are qualified and experienced in rehabilitation. These services (defined later under therapies) include but are not limited to:

- Physical therapy;
- Occupational therapy;
- Speech and language therapy;
- Psychotherapy;
- Skilled nursing/rehabilitation; and
- Respiratory therapy.

- Therapies, including:
  - Chemotherapy (inpatient and outpatient): the treatment of malignant disease by chemical or biological antineoplastic agents, including the cost of the antineoplastic;
  - Dialysis treatment: the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, to include hemodialysis or peritoneal dialysis;
  - Physical therapy: the treatment by physical means, hydrotherapy, heat or similar modalities; physical agents; bio-mechanical and neuro-physical principles; and devices to significantly relieve pain, restore maximum function lost or impaired by disease or accidental injury, and prevent disability following disease, injury or loss of body part (does not include maintenance therapy);*
  - Occupational therapy: the treatment of a physically disabled person by means of constructive activities designed and adapted to significantly improve the functional restoration of abilities lost or impaired by disease or accidental injury, to satisfactorily accomplish the ordinary tasks of daily living in the home setting (does not include maintenance therapy);*
  - Speech and language therapy: the treatment for the correction of a speech impairment when therapy is aimed at restoring the level of speech that the individual had attained before the onset of a disease, surgery, or occurrence of an accidental injury (non-medical conditions such as stuttering, articulation disorders, tongue thrusts, and lisping are not covered); and
  - Radiotherapy (inpatient and outpatient): the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.
  - Habilitative therapy: means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child’s ability to function.

*Physical/Occupational Therapy limit to 45 visits per year combined.

Specific to surgical procedures, separate payment will not be made for inpatient pre-operative care or post-operative care normally provided by the surgeon as part of the surgical procedure. For related operations or procedures performed through the same incision or in the same operative field, the plan will pay the surgical allowance for the highest paying procedure plus 50% of the surgical allowance for the second highest paying procedure and 25% of the surgical allowance for each additional procedure. When two or more unrelated operations or procedures are performed at the same operative session, the plan will pay the surgical allowance for each procedure. Surgeon fees include fees for surgery for the treatment of disease or injury, and any incision or puncture which requires the use of surgical instruments. Assistant surgeon’s fees are eligible for coverage, up to 20% of the allowed charge for the primary surgeon, when it is determined that the condition of the patient or the type of surgical service requires such assistance.

**Hospital Services**

Subject to all applicable plan limits and provisions, hospital services are generally covered at 80% after the deductible and a $250 hospital copay for services provided in-network and covered at 70% of reasonable and customary charges, after the deductible and a $250 hospital copay for services provided out of network. These services include:
• Anesthetics and oxygen, and their administration;
• Emergency services (a $100 facility copay is required for in-network or out-of-network; the facility copay is waived if patient is admitted); see the definition of medical emergency in “What to Do in an Emergency;”
• Hospital charges for covered semi-private room and board and other hospital-provided services and supplies (including inpatient rehabilitation);
• Outpatient hospital expenses eligible for outpatient hospital coverage; and
• Transplants.

Private room, intensive care, coronary care and other specialized care units of a facility are covered only when it is consistent with professional standards for the care of the patient’s condition. Facility ancillary expenses for services and supplies also are covered (subject to all of the applicable limitation and provisions of the plan). These expenses include the following:
• Use of operating, delivery and treatment rooms;
• Prescribed drugs;
• Medical and surgical dressings, supplies, casts and splints;
• Diagnostic services and therapy services; and
• Ambulance services.

**Health Management Programs**

**Health Coaching Program**

EHP members have the opportunity to work with your very own Health Coach. JHU and Healthy at Hopkins would like to partner with you, helping you to be active and stay healthy. Health Coaches are waiting to collaborate with you to create an individualized action plan for improving your health. Health Coaches assist in setting goals and offer support and encouragement to improve health and maintain healthy behaviors.

We encourage you to take the first step to improve your health today. It’s simple and provided at no cost to you. Contact your Health Coach at EHP by calling 410-762-5390 or (toll-free) 800-957-9760. You can also send an email to healthcoach@jhhc.com.

**Chronic Condition Management**

Perhaps you have already been diagnosed with a chronic condition, such as asthma or diabetes. EHP can help you learn how to better manage your chronic condition.

To qualify, you must first complete a health risk assessment. Then, you may contact EHP Care Management (toll-free) at 800-557-6916 to enroll in a care management program for diabetes or asthma. It’s also possible that EHP Care Management may reach out to you directly if your medical claims show that you are currently being treated for diabetes or asthma.

While you’re enrolled in EHP’s Care Management program, you will be paired with a personal case manager who will:
• Work with you to set and achieve personalized health goals;
• Provide you with individualized education and resources for managing your symptoms;
• Regularly review your medications, vital signs and other appropriate health information with you; and
• Help you work with your primary care physician and any specialty providers to coordinate care.
To discover more about these programs, please call **410-762-5390** or (toll-free) **800-957-9760**. Or, you can send an email to populationhealth@jhhc.com.

**Other Covered Services and Supplies**

Home health care is covered in full for services received in-network, and covered at 70% of reasonable and customary charges, after the deductible for services received out-of-network. There is a limit of 90 visits per year for both in-network and out-of-network home health care.

Durable medical and surgical equipment (rental) included in services covered are generally covered at 80% for in-network after deductible and 70% of reasonable and customary charges, after deductible, for out-of-network. Durable Medical Equipment is defined as 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.

Subject to all applicable plan limits and provisions, the following services are covered by the plan:

- Biofeedback treatment for medically necessary, non-experimental treatment of certain conditions, including:
  - Urinary and fecal incontinence;
  - Migraine and tension headaches (muscle, thermal or skin biofeedback only; EEG biofeedback is not covered for this condition);
  - Temporomandibular joint (TMJ) syndrome;
  - Neuromuscular rehabilitation of stroke and traumatic brain injury (TBI);
  - Reynaud's disease;
  - Chronic constipation;
  - Irritable bowel syndrome;
  - Refractory severe subjective tinnitus; and
  - Levator ani syndrome.
- Blood products, if not replaced;
- Convalescent facility care, home health care, hospice care and skilled nursing facility services;
- Dental services if rendered as initial emergency treatment as a result of an accident and within 48 hours of the accident;
- Diabetic supplies;
- Injectable prescription drugs, both physician-administered and self-administered (prior authorization may be required);
- Hearing aids for minor children every 36 months for one hearing aid for each hearing-impaired ear (the aid must be prescribed, fitted and dispensed by a licensed audiologist; replacement aids are available only once every three years);
- Nutritional counseling, limited to one initial consultation and one follow-up visit; additional visits covered if pre-certified;
- Prosthetic devices and orthotics that are integral to the device (including artificial limbs and eyes);
- Reproductive health;
  - Pre- and post-natal care; and
– Infertility treatment, limited to certain artificial insemination (AI)/ Intrauterine Insemination (IUI), in-vitro fertilization (IVF), and/or gamete intra fallopian transfer (GIFT) procedures. Refer to the infertility section of this chapter for applicable services and limitations.

What’s Not Covered

EHP Classic Plan does not cover the following services and supplies:

• Any condition arising from or occurring while engaged in any illegal activity;
• Any injury sustained or disease resulting from riot, rebellion, civil disobedience — or from military service in any country;
• Charges covered by no-fault auto insurance, or any other federal or state-mandated law;
• Charges for administration of any drug, including insulin;
• Charges for equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers, dehumidifiers, purifiers or physical fitness equipment, whether or not recommended by a doctor;
• Charges excluded under the “Coordination of Benefits” provisions;
• Charges that would not be made if no coverage by this plan existed;
• Charges for which you are not legally required to pay;
• Charges in excess of the reasonable and customary charge or above the allowable lifetime or annual maximums;
• Charges in connection with an injury arising out of or in the course of any employment for wage or profit;
• Charges in connection with a disease covered with respect to employment by any Workers’ Compensation law, occupational disease law or similar legislation;
• Claims filed more than 12 months after the expenses were incurred (this applies to services and supplies rendered by non-network providers for which you are required to submit the claims; network providers submit claims for you);
• Confinement, treatment, services or supplies received before your (or your eligible dependent’s) effective date of coverage under the plan or after the termination date of coverage;
• Controlled substances, hallucinogens or narcotics not administered on the advice of a doctor;
• Convenience items, such as telephone and television rental, slippers, meals for family members, or first aid kits and supplies;
• Cosmetic surgery except:
  – When resulting from an accidental injury or illness (unless the plan would exclude coverage for the injury or illness for a reason other than it occurred before coverage began);
  – Because of a congenital malformation of a child;
  – Because of a mastectomy; and
  – Because of gender reassignment.
• Coverage refused by another plan as a penalty for non-compliance with that plan’s requirements;
• Custodial care, residential care (Except as noted under the Care Management section for Mental Health and Substance Abuse), rest cures;
• Dental treatment except in connection with an accidental injury to sound natural teeth that is part of the initial emergency treatment within 48 hours after the accident;
• Drugs that are non-prescription, non-legend or over-the-counter;
• Drugs or devices not approved by the FDA for marketing and/or for the prescribed treatment of a specific diagnosis unless approved by the Johns Hopkins EHP Care Management Program; this exclusion does
not apply to a medical device to the extent Medicare would cover it in accordance with Medicare Benefit Policy Manual Chapter 14;

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

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

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- If the drug, device, equipment, treatment or procedure, or the patient informed consent document utilized with the drug, device, equipment, treatment or procedure, was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, or if Federal law requires such review or approval;
- If Reliable Evidence shows that the drug, device, equipment, treatment or procedure is the subject of ongoing phase II clinical trials; is the subject of research, experimental study or the investigational arm of ongoing phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; 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); and
- If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, equipment, treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
  - “Reliable Evidence” means published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, equipment, treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, equipment, treatment or procedure.

- Foot devices, unless (1) they are an integral part of a leg brace and the cost is included in the orthotist’s charge, or (2) they are custom-molded and related to a specific medical diagnosis (orthopedic shoes not integral to a brace, supportive devices for the feet and orthotics used for sport and leisure activities are not covered);
- Glasses, contact lenses, eye refractions, or the examinations for their fitting or prescription, except for a general vision exam once every two years at a JHU Routine Vision Network provider or when medically necessary after cataract surgery;
- Hearing aids or the examination for their fitting or prescription (except for minor children as described earlier in this document);
- Hypnosis training;
- Immunizations related to travel unless approved by the Centers for Disease Control guidelines for the countries to be visited;
- Injury sustained or an illness contracted while committing a crime;
• Injury sustained while riding a motorcycle, unless the covered person was wearing a helmet approved by Maryland state law (this exclusion applies even if wearing a helmet would not have prevented or reduced the injury);
• Marital counseling;
• Maternity care for persons other than you, your covered spouse/domestic partner, or covered dependents;
• Myopia or hyperopia correction by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy or laser surgery and all related services;
• Nicotine addiction treatment or smoking cessation programs;
• Obesity treatment, including surgical procedures for weight reduction or for treatment of conditions resulting from being overweight, except for surgical treatment of morbid obesity as described earlier in this document;
• Private room charges beyond the amount normally charged for a semiprivate room, unless a private room is medically necessary;
• Replacement of braces or prosthetic devices, unless there is sufficient change in the patient’s physical condition to make the original brace or device no longer functional;
• Reversals of sterilization procedures, such as vasectomies and tubal ligations;
• Routine foot care (including any service or supply related to corns, calluses, flat feet, fallen arches, non-surgical care of toenails, and other symptomatic complaints of the feet);
• Services and supplies not recommended and approved by a doctor;
• Services and supplies paid in full or in part under any other plan of benefits provided by JHU, a school, or a government, or for services you are not required to pay for;
• Services and supplies not specifically listed as covered in this document;
• Services performed by a doctor or other professional provider enrolled in an education, research or training program when such services are primarily provided for the purposes of the education, research or training program;
• Sexual dysfunction treatment not related to organic disease;
• Support garments, unless pre-certified by the Care Management Program;
• Surrogate motherhood treatment when the surrogate mother is not covered under this plan, including any charges related to giving birth or for treatment of the newborn child resulting from the surrogate motherhood;
• Telephone consultation charges, missed appointment charges or charges for the completion of claim forms;
• Treatment of educational and developmental disorders including but not limited to mental health services, diagnostic testing, physical, speech or occupational therapy;
• Treatment which is not medically necessary;
• Treatment which is not performed by an appropriate licensed professional provider acting within the scope of the provider’s license;
• Treatment for which a third party may be liable, unless otherwise payable (as described under “Subrogation” in this section of the Handbook);
• Treatment rendered by a health care provider who is your parent, child, grandparent, grandchild, sister, brother, great grandparent, aunt, uncle, niece or nephew or who resides in your home;
• Vision training or eye exercises to increase or enhance visual activity or coordination; and
• Wigs and artificial hair pieces (except in cases of baldness resulting from chemotherapy, radiation therapy or surgery, in which case benefits are limited to one wig once every 12 months as coordinated through the Care Management Program; the maximum allowable benefit is $350).

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 contact EHP at 800-261-2393.

**Plan Description: Kaiser Permanente HMO Plan**

Kaiser Permanente is a managed health care plan that offers comprehensive, coordinated medical care. You may choose to receive your care in any of the medical centers in Maryland, Virginia or the District of Columbia. Kaiser Permanente provides the majority of their services in a single central location (although the plan also includes some community-based providers).

**Here’s How the Kaiser Permanente Plan Works**

Under the plan, you select a primary care physician (PCP) within the medical centers or the network of physicians to receive benefits. When you need specialty care, your primary care physician (PCP) will refer you to the services needed. Most eligible expenses are covered at 100% or require a small copayment. Hospital inpatient admission requires a $250 copayment ($100 copayment for bargaining unit).

**Primary Care Physician**

You are required to select a primary care physician (PCP) when you enroll into the Kaiser Permanente Plan. Your primary care physician will be a doctor who you will develop a relationship with, who knows your medical history and can help determine the right care for you. PCPs include family or general practitioners, internists, OB/GYNs and pediatricians. You may choose a different primary care physician for each member of your family, if you wish.

When you need to see a specialist, your PCP can help you determine what treatment is right for you and will recommend an appropriate provider.

**Your Deductible**

There is no deductible.

**Your Out-of-Pocket Maximum**

Your out-of-pocket maximum is the annual limit on the amount you pay out of your own pocket for covered medical expenses. Once you reach the out-of-pocket maximum, the plan pays the full cost of your remaining covered expenses for that year, up to allowed charges and subject to coverage limits. You pay any amounts in excess of the allowed charges, any amounts above the coverage limit, and any uncovered expenses. Expenses incurred in one year cannot be applied towards meeting your out-of-pocket maximum in the next year. The out-of-pocket maximums are as follows:
### Annual out-of-pocket maximum

<p>| | |</p>
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,500</td>
</tr>
<tr>
<td>1 Adult and Child(ren)</td>
<td>$7,000 for Adult + one child; $9,400 for Adult + two or more children</td>
</tr>
<tr>
<td>2 Adults</td>
<td>$7,000</td>
</tr>
<tr>
<td>2 Adults and Child(ren)</td>
<td>$9,400</td>
</tr>
</tbody>
</table>

### Emergency Services

In a medical emergency, at home or away from home, seek help immediately at the nearest hospital emergency room, urgent care facility, or doctor’s office. If you experience a medical emergency you should contact 911 immediately. If you are not sure if you are experiencing a medical emergency, contact Kaiser Permanente at the number listed on the reverse side of your ID card for immediate medical advice. (For a definition of “medical emergency,” see “What to Do in an Emergency.”)

To apply for appropriate benefits, you or an appropriate designee must call the medical advice line within 48 hours of the visit to the hospital emergency room.

Coverage is not provided if you use an emergency room (or other emergency facility) for care that is not considered a medical emergency.

Of course, you and your physician should make an independent determination about what care is appropriate for you, and you should not base this determination on whether the plan will or will not provide coverage for that care.

### What’s Covered by the Kaiser Permanente HMO

#### Preventive Care Services

Subject to all plan limits and provisions, preventive care services are generally covered at 100%. These services include:

- Diagnostic testing and health exams for prevention, detection and treatment of a disease, at intervals appropriate to your age, sex and health status or for which you have been determined to be a high risk for contracting;
- Cancer screenings, including:
  - Prostate-specific antigen (PSA) tests and digital rectal exams (for men between 40 and 75 years of age or otherwise at high risk);
  - Pap smears, at intervals appropriate to your age and health status;
  - Mammography services, at intervals appropriate to your age and health status; and
  - Colorectal screening, in accordance with the most current guidelines issued by the American Cancer Society.
- Bone mass measurement for the prevention, diagnosis and treatment of osteoporosis;
- Allergy testing and treatment, including administration of injections and allergy serum;
- Routine adult physical exams;
• Routine obstetric and gynecological care, including health care services incidental to and rendered during an annual visit;
• Well-child preventive care and pediatric services in accordance with the most recent guidelines of the American Academy of Pediatrics; and
• Diabetes screenings for adults with blood pressure levels above specified limits;
• Pneumonia vaccines for adults under age 65 with certain risk factors;
• Annual flu shots; and
• Zoster vaccination (for shingles) for adults age 60 or older.

The following additional preventive care services for women are also covered at 100%:
• Annual well-woman office visit;
• All Food and Drug Administration (FDA)-approved contraceptive methods and sterilization procedures for women, in addition to patient education and counseling;
• Comprehensive lactation support and counseling for women;
• Human papillomavirus (HPV) testing for women ages 30 and older;
• HIV counseling and screening for women;
• Domestic violence screening and counseling for women;
• Counseling on sexually transmitted infections for women;
• Screening for gestational diabetes for women;
• Hepatitis B screenings for pregnant women; and
• Generic contraceptives.

**Physician and Provider Services**

Subject to all plan limits and provisions, physician services are generally covered at 100% after a $15 copay ($30 for specialist visits) for bargaining unit employees and $20 copay ($35 for specialist visits) for faculty and staff:

These services include:
• Primary care visits for internal medicine, family practice, pediatrics, and obstetrics and gynecology (copays do not apply to preventive care visits);
• Specialty care visits;
• Outpatient surgery;
• Anesthesia;
• Chemotherapy and radiation therapy;
• Respiratory therapy;
• Medical social services;
• House calls when care can best be provided in your home as determined by your primary care physician;
• After hours urgent care received after the regularly scheduled hours of the primary care physician; and
• Consultations and immunizations for foreign travel.

**Hospital Services**

Subject to all plan limits and provisions, hospital services are generally covered at 100% after a $250 hospital copay. (This does not apply to bargaining unit employees.) These services include:
• Room and board, including a private room when deemed medically necessary;
• Specialized care and critical care units;
• General and special nursing care;
• Surgical care (inpatient services 100% covered after $250 hospital copay (faculty and staff only); outpatient services 100% covered after $100 copay for faculty and staff ($50 copay for bargaining unit) including:
  – Use of operating and recovery room;
  – Use of special procedure rooms;
  – Anesthesia services and supplies;
  – Diagnostic procedures, laboratory tests and x-ray services;
  – Drugs, medications, solutions, biological preparations and services associated with the administration of the same;
  – Medical and surgical supplies; and
  – Blood, blood plasma products, and related donor processing fees that are not replaced by or on behalf of the patient (including infusions).
• Plan physicians’ and surgeons’ services, including consultation and treatment by specialists. (For faculty and staff, specialist services 100% covered after $35 specialist copay. For bargaining unit employees, specialist services covered at 100% after $30 copay);
• Chemotherapy and radiation therapy;
• Respiratory therapy;
• Medical social services and discharge planning;
• Emergency services require a $100 copay per hospital visit and the $250 hospital copay will apply for faculty and staff, (waived if admitted);
• Urgent care for life threatening or serious emergencies is subject to a $50 copay per visit for faculty and staff; and a $30 copay per visit for bargaining unit employees; non-plan providers are covered only outside the service area; and
• Ambulance services ($100 copay for faculty and staff; $75 copay for bargaining unit) if:
  – Your condition requires either the basic life support, advanced life support or critical care life support capabilities in an ambulance for inter-facility or home transfer; and
  – The ambulance transportation has been ordered by a primary care physician (coverage is also provided for medically necessary transportation or services rendered as the result of a 911 call).

**Mental Health and Substance Abuse Services**

Subject to all plan limits and provisions, covered mental health and substance abuse services include:
• Therapy prescribed or directed by a physician, including:
  – Individual therapy;
  – Group therapy; or
  – Drug therapy.
• Education (prescribed or directed by a physician);
• Psychiatric nursing care;
• Appropriate hospital services (medical services for detoxification are limited to the removal of the toxic substance or substances from the system);
• Outpatient services from physician or other health care professionals to treat mental illness, emotional disorders, drug abuse and alcohol abuse, including but not limited to:
  – Evaluations;
– Crisis intervention;
– Psychological and neuropsychological testing for diagnostic purposes;
– Medical treatment for withdrawal symptoms; and
– Visits for the purpose of monitoring drug therapy.

Other Covered Services

Home health care is generally covered in full.

Basic Durable Medical Equipment is generally covered in full. Durable Medical Equipment is defined as equipment that (1) is intended for repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) is generally not useful to a person in the absence of illness or injury, and (4) meets medical necessity criteria. Please note:

• Coverage is limited to the standard item of equipment that adequately meets your medical needs;
• Repairs or replacement of equipment is covered; and
• Diabetes equipment and supplies are covered separately.

Subject to all plan limits and provisions, the following other services are covered by the plan:

• Diabetes equipment, diabetes supplies, and diabetes outpatient self-management training and education services, including medical nutrition therapy for:
  – Insulin-using diabetes;
  – Insulin-dependent diabetes;
  – Non-insulin using diabetes; and
  – Elevated blood glucose levels induced by pregnancy, including gestational diabetes.

• Diabetic equipment and supplies, when prescribed by a physician, including:
  – Insulin pump;
  – Blood/urine testing agents, including glucose test tablets, glucose test tape, glucose meters and acetone test tablets; and
  – Disposable needles and syringes in quantities needed for injecting prescribed insulin.

• Dialysis:
  – Outpatient maintenance dialysis treatments in a dialysis facility (including the cost of laboratory tests, equipment, supplies and other services associated with your treatment);
  – Inpatient maintenance dialysis if you are admitted to a hospital because your medical condition requires specialized hospital services on an inpatient basis;
  – Physician services related to inpatient and outpatient dialysis;
  – Self-dialysis (training for self-dialysis at home, services of the provider who is conducting your self-dialysis training, retraining for use of new equipment for self-dialysis); and
  – Home dialysis (hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD)).

• Supplemental Durable Medical Equipment prescribed by a physician if your medical condition meets the criteria for medical necessity:
  – Oxygen and equipment;
  – Positive airway pressure equipment (continuous and bi-level);
  – Apnea monitors for infants under age three, for a period not to exceed six months;
  – Asthma equipment (spacers, peak-flow meters, nebulizers); and
  – Bilirubin lights for infants under age three, for a period not to exceed six months.

• Reproductive Health including:
- Pre- and post-natal care; and
- Infertility services, which are limited to infertility counseling, testing, artificial insemination and in-vitro fertilization. Please note: Coverage for infertility services usually requires pre-authorization by the HMO; be sure to check with your primary care physician for requirements and limits.

- Eye examinations for the diagnosis and treatment of a medical condition (annual routine eye examinations and eye refraction);
- Routine hearing screenings ($20 copay as part of a health assessment);
- Hearing aid coverage (minor children only);
- Rehabilitation services, including occupational therapy, physical therapy and speech therapy;
- Organ and tissue transplants, limited to the following procedures: kidney; cornea transplants; liver transplants for children with biliary artresia; autologous bone marrow or stem cell transplants that are not experimental or investigational; allogeneic bone marrow or stem cell transplants that are not experimental or investigational; immunosuppressant maintenance drugs; donor services not covered under any other health insurance plan or by any other source; and the cost of hotel lodging and air transportation for the recipient and a companion (or two companions if the patient is under the age of 18 years) to and from the site of the transplant. This is available only if approved by the HMO and only if the covered transplant is not performed in the service area;
- Maternity benefits, including maternity services (obstetrical care, prenatal, delivery, postnatal care; coverage for a hospital stay; coverage for care from approved licensed birthing center; collection of adequate samples for hereditary and metabolic newborn screening and follow-up; newborn hearing screening prior to discharge) and postpartum home visits (in accordance with the most current standards published by the American College of Obstetricians and Gynecologists);
- Birthing classes, one course per pregnancy at an approved facility;
- Surgical treatment of morbid obesity (Please note: Kaiser covers this service only if the procedure is medically necessary and only if the member follows a pre-surgery program specified by his/her Primary Care Physician (PCP)); and
- Hair prosthetics resulting from chemotherapy or radiation therapy.

What’s Not Covered

The Kaiser Permanente Plan does not cover the following services:
- Chiropractic services and the services of a chiropractor, acupuncture, naturopathy and massage therapy,
- Physical examinations and other services required for obtaining or maintaining employment or participation in employee programs, or required for insurance or licensing, or on court-order or required for parole or probation (this exclusion does not apply if the plan provider determines that the services are medically necessary);
- Cosmetic services that are intended primarily to improve your appearance and that will not result in significant improvement in physical function, except for services covered under reconstructive surgery, cleft lip or cleft palate or as medical necessary in connection with transgender services;
- Custodial care services (care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse, such as helping with walking, bathing, dressing, feeding, toileting and taking medicine);
- Dental care and dental x-rays, including dental appliances, dental implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any dental treatment involved in temporal mandibular joint (TMJ) pain dysfunction syndrome, unless otherwise covered (this exclusion does not apply to medically necessary dental care covered under accidental dental injury services, cleft-lip, cleft-palate or oral surgery);
• Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices;

• Durable Medical Equipment not listed as part of the covered services (including but not limited to comfort, convenience, or luxury equipment or features; exercise or hygiene equipment; non-medical items such as sauna baths or elevators; modifications to your home or car; electronic monitors of the heart or lungs, except infant apnea monitors);

• Experimental or investigational services. A service is experimental or investigational for your condition if, at the time the service is or will be provided to you, any of the following apply:
  – The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration (“FDA”) and such approval has not been granted; or
  – Is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted;
  – The service is subject to the approval or review of an Institutional Review Board (“IRB”) of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
  – The service is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively:
  – Your medical records;
  – The written protocols or other documents pursuant to which the service has been or will be provided;
  – Any consent documents you or your representative has executed or will be asked to execute, to receive the service;
  – The files and records of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;
  – The published authoritative medical or scientific literature regarding the service, as applied to your illness or injury; and/or
  – Regulations, records, applications and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

• Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids (except as otherwise provided for minor children);

• Payment of any claim, bill or other demand or request for payment for covered services determined to be furnished as the result of a referral prohibited by law;

• Psychological and neuropsychological testing for ability, aptitude, intelligence or interest;

• Routine foot care services that are not medically necessary (this exclusion does not exclude services when you are under active treatment for a metabolic or peripheral vascular disease);

• Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation other than licensed ambulance, even if it is the only way to travel to a hospital or plan provider;

• Non-plan provider services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the services are covered as out-of-plan emergency services.
Getting Assistance

Member Services representatives are available at Kaiser’s Plan Medical Offices and through the Call Center to answer any questions you have about your benefits, available services and the facilities where you can receive care. These representatives can also help you submit a request for payment and/or reimbursement for emergency services and urgent care services outside the service area or to initiate an appeal or a grievance for any unresolved problem.

Discuss any problems with your primary care plan provider or other health care professionals treating you. If you are not satisfied with your primary care plan provider, you can request a different plan provider by calling the Member Services Call Center.

Visiting Other Health Plan or Allied Plan Service Areas

If you visit a service area (different from your provider service area) temporarily — but not more than 90 days — you can receive visiting Member care from designated providers in that area. The covered services, copayments, coinsurance and deductibles may differ from those in your service area, and are governed by the HMO program for visiting members.

This visiting area program does not cover certain services, such as transplant services or infertility services. Also, except for out-of-plan emergency services, your right to receive covered services in the visited service area ends after 90 days unless you receive prior written authorization to continue receiving covered services in the visited service area. The 90 day limit on visiting member care does not apply to a covered child who is out of area while attending an accredited college or accredited vocational school.

Service areas and facilities where you may obtain visiting Member care may change at any time.

Copayment Maximum

For Kaiser Permanente, the Plan Year copay maximum of $3,500 per individual/$9,400 per family is the limit to the total amount of copayments and coinsurance you must pay annually. Once you have met the copayment maximum, you will not be required to pay any additional copayments for basic health services, but you will have to continue to pay copays for services that are not basic health services.

The following services are considered “basic health services” that apply toward the copayment maximum:

- Inpatient and outpatient physician services;
- Inpatient hospital services;
- Outpatient medical services;
- Emergency services;
- X-ray, laboratory and special procedures; and
- Inpatient and outpatient chemical dependency and mental health services.

Plan Description: CareFirst BlueCross BlueShield Plan III

This plan provides traditional indemnity-type medical coverage, which means you pay your deductible first, and then you pay a portion of the cost (your coinsurance amount) each time you use medical services. There are limits to the amount you have to pay out of your pocket each year (your out-of-pocket maximum).
Once you meet your out-of-pocket maximum, the plan pays 100% of the remaining eligible expense for that year. For preventive services, your coverage is 100% before the deductible.

**Here’s How the Plan Works**

- You obtain medical care from the provider (such as a doctor or hospital) of your choice. The provider charges a fee for each medical service. If the service is a covered service, your payment will depend on the provider you choose.
- The plan generally pays benefits after you pay your annual deductible (except for preventive services, which do not require a deductible). You will pay a percentage of allowed benefits for covered services.
- When your share of covered expenses in a calendar year reaches your out-of-pocket maximum, the plan pays the full charges of remaining covered expenses for that year, subject to plan limits.
- You or your provider files a claim for reimbursement of covered expenses.

**Allowed Benefits**

An allowed benefit is the maximum the plan will pay for a covered service. Under CareFirst BlueCross BlueShield Plan III, for physician and non-facility services, the allowed benefit is the amount the plan has agreed to pay to providers who contract with the plan’s provider network to be paid directly for covered services. For health care facilities, the allowed charge is the rate approved by the Health Services Cost Review Commission. For facilities over which the Health Services Cost Review Commission does not have authority, the allowed charge is the amount agreed upon by the facility and the plan.

If you use a provider who is not a participant in one of the preferred provider networks, your provider may bill you (or your covered dependent) for the difference (or balance) of charges above the amount the plan has set as an allowed benefit. For example, let’s say you saw a specialist for outpatient care. If we assume your deductible has already been met, your plan will pay for 50% of the allowed benefit for your visit; you will be responsible for the 50% of the allowed benefit of your visit. Your provider charged you $250 for the visit, but the allowed benefit set by the plan is $200. You will be responsible for a total charge of $150:

<table>
<thead>
<tr>
<th>A. Charge by specialist</th>
<th>$250</th>
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</thead>
<tbody>
<tr>
<td>B. Allowed benefit for comparable service</td>
<td>$200</td>
</tr>
<tr>
<td>C. Your portion (50%) of allowed benefit</td>
<td>$100</td>
</tr>
<tr>
<td>D. Balance billing (amount charged by specialist over the allowed benefit)</td>
<td>$250 minus $200</td>
</tr>
<tr>
<td>E. Your total cost: your portion of allowed benefit plus balance billing (line C. plus line D.)</td>
<td>$150</td>
</tr>
</tbody>
</table>

**Your Deductible**

You must pay an amount each calendar year before the plan begins to pay benefits for most covered services. This amount is called the deductible. If the service is a covered service, your payment will depend on the provider you choose. Once you reach your annual deductible, the plan pays a percentage of the allowed benefit, subject to option limits, for your remaining covered expenses in that year.
The deductible amounts for the CareFirst BlueCross BlueShield Plan III are as follows:

<table>
<thead>
<tr>
<th>Level of Coverage</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>1 Adult and Child(ren)</td>
<td>$6,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>2 Adults</td>
<td>$6,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>2 Adults and Child(ren)</td>
<td>$6,000</td>
<td>$12,000</td>
</tr>
</tbody>
</table>

The deductible does not apply to some services.

<table>
<thead>
<tr>
<th>Level of Coverage</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
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<tr>
<td>1 Adult and Child(ren)</td>
<td>$1,200</td>
<td></td>
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<td>2 Adults</td>
<td>$1,200</td>
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<tr>
<td>2 Adults and Child(ren)</td>
<td>$1,200</td>
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</tbody>
</table>

Understanding the Combined Deductible Limit

If you enroll for coverage for you and your spouse or domestic partner, you and your child, or your entire family, the limit listed above is the combined amount you and your covered dependents have to pay in deductibles each calendar year. Your family won’t have to pay more in deductibles for the year than the combined amount that applies to your level of coverage, regardless of whether you or any covered family member reach the individual deductible.

Expenses That Don’t Count Toward the Deductible

Some expenses don’t count toward your deductible. These include amounts you pay:

• Above allowed charges;
• Above the coverage limit;
• For any uncovered expenses; and
• As copayment for inpatient admission.

Your Out-Of-Pocket Maximum

Your out-of-pocket maximum is the annual limit you pay out of your own pocket for covered medical expenses, including your deductible, copayments and coinsurance.

Once you reach the out-of-pocket maximum, the plan pays the full cost of your remaining covered expenses for that year, up to allowed charges and subject to any benefit-specific coverage limits that may apply. You would still be responsible for paying any amounts in excess of the allowed charges, any amounts above a coverage limit that applies to a specific benefit, and any expenses for uncovered expenses. Expenses incurred in one year cannot be applied towards meeting your out-of-pocket maximum in the next year. The out-of-pocket maximums are as follows:
### Understanding your Combined Out-Of-Pocket Maximum

If you enroll for coverage for you and any other family member, the limit listed above is the combined amount you and those covered through you have to pay out-of-pocket each calendar year for covered expenses. Your family won’t have to pay more out-of-pocket for the year than the combined limit that applies based on your level of coverage, up to allowed charges, whether or not you or any dependent reach the individual out-of-pocket maximum. Also, if any individual covered family member reaches his or her individual out-of-pocket maximum, the plan pays the full cost of your remaining covered expenses for that year for that individual family member, up to allowed charges and subject to any benefit-specific coverage limits that may apply. You would still be responsible for paying any amounts in excess of the allowed charges, any amounts above a coverage limit that applies to a specific benefit, and any expenses for uncovered expenses.

### Expenses that Don't Count Toward The Out-Of-Pocket Maximum

Some expenses don’t count toward your individual or combined out-of-pocket maximum. These include amounts you pay:

- Above reasonable and customary charges;
- Above any plan limit;
- For any price difference between a brand name drug and a generic equivalent, if a generic is available and appropriate (as determined by your physician); and
- For any uncovered expenses

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### Annual Medical Out-Of-Pocket Maximum

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
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### Annual Prescription Drug Out-of-Pocket Maximum

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<td>$3,200</td>
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</table>
Emergency Services

Emergency services are those health care services that are rendered after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possess an average knowledge of health and medicine to result in:

- Serious jeopardy to the mental or physical health of the individual;
- Danger of serious impairment of the individual’s bodily functions;
- Serious dysfunction of any of the individual’s bodily organs; or
- For a pregnant woman, serious jeopardy to the health of the fetus.

Examples might include, but are not limited to: heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings and other acute conditions as CareFirst determines.

For a definition of “medical emergency,” see “What to Do in an Emergency.”

Of course you and your physician should make an independent determination about what care is appropriate for you, and you should not base this determination on whether the plan will or will not provide coverage for that care.

What’s Covered by the CareFirst BlueCross BlueShield Plan III

Preventive Care Services

Subject to all plan limits and provisions, services for preventive care are generally covered at 100%. These services include:

- Annual adult physical exams;
- Well-baby care for routine immunizations, screening tests or follow-up visits between birth and four weeks of age;
- Well-child care (through age 17);
- Immunizations (included in routine office visit);
- Mammograms (routine); coverage provided in accordance with the latest guidelines from the American Cancer Society;
- Diabetes screenings for adults with blood pressure levels above specified limits;
- Pneumonia vaccines for adults under age 65 with certain risk factors;
- Annual flu shots;
- Zoster vaccination (for shingles) for adults age 50 or older; and

The following additional preventive care services for women are also covered at 100%:

- Annual well-woman office visit;
- All Food and Drug Administration (FDA)-approved contraceptive methods and sterilization procedures for women, in addition to patient education and counseling;
- Comprehensive lactation support and counseling for women;
- Human papillomavirus (HPV) testing for women ages 30 and older;
- HIV counseling and screening for women;
• Domestic violence screening and counseling for women;
• Counseling on sexually transmitted infections for women;
• Screening for gestational diabetes for women;
• Hepatitis B screenings for pregnant women; and
• Generic contraceptives (covered under Express Scripts).

**Physician and Provider Services**

Subject to all plan limits and provisions, physician services are generally covered at 50% of allowed benefit after the deductible. These services include:

- Office visits;
- Medical and surgical services;
- Specialist care (inpatient);
- Second surgical opinion (no deductible); and
- Diagnostic services (outpatient).

Physician services provided in an outpatient hospital facility are covered at 50% of allowed benefit, after the deductible.

**Hospital Services**

Subject to all plan limits and provisions, hospital services are generally covered at 50% of allowed benefit, after the deductible. These services include:

- Hospital service benefits (inpatient) for bed, board and routine nursing services in a semi-private, private room or a CareFirst special care unit. Related hospital service, medical supplies, equipment and private duty nursing services are covered;
- Outpatient surgery expenses for ambulatory surgery;
- Emergency care (in and out-of-network) for a medical emergency, trauma or accident and emergency care follow up visits is generally covered at 50% of allowed benefit after the deductible; and
- Ambulance services for transport within local area or closest hospital from a place of accident to a hospital for a medical emergency. Transport is also provided between hospital and nursing health care facility or residence.

For purposes of determining hospital service coverage, see the definition of medical emergency in “What to Do in an Emergency.”

**Mental Health and Substance Abuse Services**

Mental health treatment is the treatment of an acute psychiatric disorder that can be expected to improve significantly through short-term medically necessary therapy. Substance abuse treatment is the effective treatment of chemical dependency on alcohol or drugs under the supervision of a provider that is certified by the Alcohol and Drug Abuse Administration of the Maryland Department of Health and Mental Hygiene. Subject to all plan limits and provisions, covered services for mental health and substance abuse include:

- Mental and nervous (inpatient) treatment in a hospital or treatment facility for bed, board and services in a semi-private and private room; hospital services, supplies and practitioner services are covered;
- Mental and nervous (outpatient) treatment provided in a facility approved by CareFirst for services or psychiatric day treatment benefits;
• Alcohol and drug addiction (inpatient) expenses for bed, board and services in a healthcare facility specializing in the rehabilitation of drug users and certified by the Alcohol and Drug Abuse Administration of the Maryland Department of Health and Mental Hygiene as a Residential Drug Free Treatment Rehabilitation Program; and

• Alcohol and drug addiction (outpatient) therapy services, counseling, psychological testing and other health care services prescribed for drug abuse rehabilitation rendered in a non-residential setting by a certified provider for an outpatient drug-free treatment program, outpatient chemotherapeutic treatment program and outpatient drug abuse counseling programs (crisis intervention programs and hotlines are not included).

Total Care and Cost Improvement

Total Care and Cost Improvement (TCCI) is an umbrella program for qualified Members, aimed at providing improved quality of care by coordination of services, across provider type, setting and time, for those at high risk or with multiple chronic conditions. TCCI encompasses programs including, but not limited to, Health Promotion, Wellness and Disease Management Services Program (WDM), Hospital Transition of Care Program (HTC), Complex Case Management Program (CCM), Chronic Care Coordination Program (CCC), Behavioral Health and Substance Use Disorder Program (BSD), Home-Based Services Program (HBS), Enhanced Monitoring Program (EMP).

The vehicle for all care coordination efforts in the TCCI program array is the care plan. There are three TCCI programs that employ care plans: CCC, CCM and BSD. Essential to care coordination and case management is the Member’s consent to the creation, maintenance and faithful adherence to a care plan. Qualified Members who are compliant in their care plans may be eligible for a cost share waiver (i.e. copays, coinsurance, and deductibles) for services rendered outside of a hospital setting and during their participation in the program.

To learn more about the TCCI programs, you may call CareFirst at 877-691-5856. You may also ask the Benefits Service Center for a copy of the Evidence of Coverage. Additional information can also be found on the CareFirst website here: https://individual.carefirst.com/carefirst-resources/provider/pdf/pcmh-program-description-guidelines.pdf.

Other Covered Services

Home health care for in-home care and services by or through a home health care agency within 72 hours after a hospital stay is an alternative to staying in a hospital. This care must follow the plan of treatment designated by the attending physician or a hospital medical director and be approved by CareFirst. Home health care is generally covered in full. There is a limit of 90 visits per year.

Durable Medical Equipment is defined as equipment prescribed and certified by health care practitioner for medical condition and therapeutic use. Air conditioners, humidifiers, exercise equipment, elevators and ramps are not included. Durable Medical Equipment is generally covered at 50% after the deductible.

Subject to all plan limits and provisions, the following other services are covered by the plan:

• Reproductive health care, including:
  – Pre- and post-natal care;
  – Family planning and fertility testing;
  – Artificial insemination (requires authorization by the plan); and
  – In-vitro fertilization (refer to the infertility section of this chapter for applicable services and limitations).
• Hearing exams and hearing aids for minor children (covered at 100% of allowed benefit every 36 months for one hearing aid for each hearing impaired ear);
• Physician-administered injectibles (self-injectibles are covered under the prescription plan); and
• Prescription drugs (drugs, biologicals and compounded prescriptions prescribed by a health care practitioner and pre-approved by CareFirst on an exception basis).

What’s Not Covered

The plan will not provide a benefit for:

• Any service, supply or item that is not medically necessary. Although a service may be listed as covered, benefits will be provided only if the service is medically necessary as determined by CareFirst;
• Services that are experimental/investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst;
• Services or supplies received at no charge to a Member in any federal hospital, or through any federal, state or local governmental agency or department, or not the legal obligation of the Member, or where the charge is made only to insured persons; this exclusion does not apply to:
  – Medicaid;
  – Benefits provided in any state, county, or municipal hospital in or out of the state of Maryland; or
  – Care received in a Veteran’s hospital unless the care is rendered for a condition that is a result of a Member’s military service.
• Services that are not specifically shown in this document as a Covered Service or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Provision of services, even if Medically Necessary, by a Participating Provider or PPO Provider does not, by itself, entitle a Member to benefits if the services are excluded or do not otherwise meet the conditions and criteria for coverage;
• Routine, palliative, or cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet;
• Routine dental care such as services, supplies, or charges directly related to the care, filling, removal or replacement of teeth, the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth;.
• Cosmetic services (except for mastectomy-related services, services for cleft lip or cleft palate or both or transgender services);
• Treatment rendered by a health care provider who is the Member’s parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or who resides in the Member’s home;
• Outpatient prescription drugs unless otherwise stated;
• All non-prescription drugs, medications, biologicals, and over-the-counter disposable supplies, routinely obtained and self-administered by the Member, except as described under “What’s Covered by the CareFirst BlueCross Blue Shield Plan III;”
• Lifestyle improvements, including, but not limited to: smoking cessation, health education classes and self-help programs except as described under “What’s Covered by the CareFirst BlueCross BlueShield Plan III;”
• Fees or charges relating to: fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, use of passive or patient-activated exercise equipment;
• Treatment for weight reduction and obesity except for the surgical treatment of morbid obesity;
• Routine eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, except contact lenses when there is a diagnosis of Keratoconus;
• Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications;
• Services furnished as a result of a referral prohibited by law;
• Any service related to recreation activities. This includes, but is not limited to: sports, games, equestrian activities and athletic training, even though such services may be deemed to have therapeutic value;
• Non-medical, health care provider services, including, but not limited to:
  – Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the health care provider or his/her staff; or
  – Administrative fees charged by a health care provider to a Member to retain the health care provider’s medical practices services, e.g., “concierge fees” or boutique medical practice membership fees. Benefits under the Evidence of Coverage are limited to Covered Services rendered to a Member by a health care provider.
• Educational therapies intended to improve academic performance;
• Vocational rehabilitation, and employment counseling;
• Services related to an excluded service (even if those services or supplies would otherwise be covered services) except General Anesthesia & Associated Hospital or Ambulatory Surgical Facility Services for Dental Care;
• Separate billings for health care services or supplies furnished by an employee of a health care provider which are normally included in the health care provider’s charges and billed by them;
• Services that are non-medical in nature, including, but not limited to: personal hygiene, cosmetic and convenience items such as air conditioners, humidifiers, exercise equipment, elevators or ramps;
• Personal comfort items, even when used by a Member in an inpatient hospital setting, such as telephones, televisions, guest trays or laundry charges;
• Custodial, personal or domiciliary care that is provided to meet the activities of daily living, e.g., bathing, toileting and eating (care which may be provided by persons without professional medical skills or training);
• Self-care or self-help training designed to enable a Member to cope with a health problem or to modify behavior for improvement of general health unless otherwise stated;
• Travel, whether or not advised by a health care practitioner. Limited travel benefits related to an organ transplant or serious illness or injury may be covered;
• Services intended to increase the intelligence quotient (IQ) of Members with intellectual disability or to provide cure for primary developmental disabilities, if such services do not fall within generally accepted standards of medical care;
• Services for the purpose of controlling or overcoming delinquent, criminal or socially unacceptable behavior unless deemed Medically Necessary by CareFirst;
• Milieu care or in-vivo therapy: care given to change or control the environment, supervision to overcome or control socially unacceptable behavior, or supervised exposure of a phobic individual to the situation or environment to which an abnormal aversion is related;
• Dietary or nutritional counseling, diabetes equipment, supplies and self-management training;
• Tinnitus maskers, purchase, examination, or fitting of Hearing Aids except as described under “What’s Covered by the CareFirst BlueCross BlueShield Plan III;”
• Except as specifically described in this document, services related to human reproduction including, but not limited to: maternity services for surrogate motherhood or surrogate uterine insemination, unless the surrogate mother is a Member;
• Blood products and whole blood when donated or replaced;
• Oral surgery, dentistry or dental processes unless otherwise stated;
• Treatment of temporomandibular joint disorders unless otherwise stated;
• Premarital exams;
• Services performed or prescribed by or under the direction of a person who is not a health care provider;
• Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice;
• Services provided through a dental or medical department of an employer; a mutual benefit association, a labor union, a trust or a similar entity;
• Services rendered or available under any Worker’s Compensation or occupational disease, or employer's liability law, or any other similar law, even if a Member fails to claim benefits;
• Services provided or available through an agent of a school system in response to the requirements of the Individuals With Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students within the educational system, even when such services are of the nature that they are Covered Services when provided outside the educational domain;
• Illnesses resulting from an act of war;
• Charges used to satisfy a Member’s dental care, prescription drug, or vision care benefits deductible, if applicable, or balances from any such programs;
• Legal services;
• Contraceptive devices and drugs, including insertion or removal and related examination unless otherwise stated or
• Hearing care except as otherwise stated.

**Plan Description: BlueChoice HMO Plan (This plan is closed to new faculty and staff participants effective January 1, 2010)**

BlueChoice is a health maintenance organization (HMO) — a managed health care plan that offers comprehensive medical care.

**Here’s How the HMO Works**

Under an HMO plan, you must use the HMO’s doctors and facilities to receive benefits. The BlueChoice network consists of independent physicians with offices located throughout the community. Most eligible expenses are covered at 100% or require a small copayment. Hospital inpatient admission requires a $250 copayment for faculty and staff.

**Primary Care Physician**

You are required to select a primary care physician (PCP) when you enroll in an HMO. Your PCP will be a doctor who knows you and your medical history, and can help determine the right care for you. PCPs include family or general practitioners, internists, OB/GYNs and pediatricians. You may choose a different PCP for each member of your family, if you wish.
When you need to see a specialist, your PCP can help you determine what treatment is right for you and will recommend an appropriate provider. However, you do not need to get a referral from your PCP for specialist services to be covered.

Your Deductible

There is no deductible.

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the annual limit on the amount you pay out of your own pocket for covered medical expenses. Once you reach the out-of-pocket maximum, the plan pays the full cost of your remaining covered expenses for that year, up to allowed charges and subject to coverage limits. You pay any amounts in excess of the allowed charges, any amounts above the coverage limit, and any uncovered expenses. Expenses incurred in one year cannot be applied towards meeting your out-of-pocket maximum in the next year. The out-of-pocket maximums are as follows:

- For Faculty and Staff:

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<thead>
<tr>
<th>Annual out-of-pocket maximum</th>
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<tbody>
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- For Bargaining Unit Employees:

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<tr>
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<td>$1,500</td>
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Emergency Services

A medical emergency is the sudden onset of a medical condition with severe symptoms in which the absence of medical attention could lead to serious impairment to bodily functions or serious dysfunction of any organ, or place a patient’s health in serious jeopardy.
In a medical emergency, at home or away from home, seek help immediately at the nearest hospital emergency room, urgent care facility or doctor’s office. If you experience a medical emergency you should contact 911 immediately. If you are not sure whether you are experiencing a medical emergency, contact BlueChoice at the number listed on the reverse side of your ID card for immediate medical advice.

To apply for appropriate benefits, you or an appropriate designee must call the medical advice line within 48 hours of the visit to the hospital emergency room.

Coverage is not provided if you use an emergency room (or other emergency facility) for care that is not considered a medical emergency.

Of course, you and your physician should make an independent determination about what care is appropriate for you, and you should not base this determination on whether the plan will or will not provide coverage for that care.

**What’s Covered by the BlueChoice HMO**

**Preventive Care Services**

Subject to all applicable plan limits and provisions, preventive care services are generally covered at 100%. These services include:

- Diagnostic testing and health exams for prevention, detection, and treatment of a disease, at intervals appropriate to your age, sex and health status or for which you have been determined to be a high risk for contracting;
- Cancer screening, including:
  - Prostate-specific antigen (PSA) tests and digital rectal exams (for men between 40 and 75 years of age or otherwise at high risk);
  - Pap smears, at intervals appropriate to your age and health status;
  - Mammography services, at intervals appropriate to your age and health status; and
  - Colorectal screening, in accordance with the most current guidelines issued by the American Cancer Society.
- Bone mass measurement for the prevention, diagnosis and treatment of osteoporosis;
- Allergy testing and treatment, including administration of injections and allergy serum;
- Annual adult physical exams;
- Well-child preventive care and pediatric services in accordance with the most recent guidelines of the American Academy of Pediatrics;
- Diabetes screenings for adults with blood pressure levels above specified limits;
- Pneumonia vaccines for adults under age 65 with certain risk factors;
- Annual flu shots; and
- Zoster vaccination (for shingles) for adults age 50 and older.

The following additional preventive care services for women are also covered at 100%:

- Annual well-woman office visit;
- All Food and Drug Administration (FDA)-approved contraceptive methods and sterilization procedures for women, in addition to patient education and counseling;
- Comprehensive lactation support and counseling for women;
- Human papillomavirus (HPV) testing for women ages 30 and older;
- HIV counseling and screening for women;
• Domestic violence screening and counseling for women;
• Counseling on sexually transmitted infections for women;
• Screening for gestational diabetes for women;
• Hepatitis B screenings for pregnant women; and
• Generic contraceptives (covered under Express Scripts).

**Physician and Provider Services**

Subject to all plan limits and provisions, physician services are generally covered 100% after a $15 copay ($30 copay for specialist visits) for bargaining unit employees and $20 copay ($35 for specialist visits) for faculty and staff. These services include:

• Primary care visits for internal medicine, family practice, pediatrics, and obstetrics and gynecology;
• Specialty care visits;
• Outpatient surgery;
• Anesthesia;
• Chemotherapy and radiation therapy;
• Respiratory therapy;
• Medical social services;
• Home care when care can best be provided in your home as determined by your primary care physician;
• After hours urgent care received after the regularly scheduled hours of the primary care physician; and
• Consultations and immunizations for foreign travel; preventive exams and immunizations “solely for travel” are covered at 100% of the allowed benefit (not subject to deductible).

**Hospital Services**

Subject to all plan limits and provisions, hospital services are generally covered at 100%. There is a $250 hospital copay for faculty and staff. These services include:

• Room and board, including a private room when deemed medically necessary;
• Specialized care and critical care units;
• General and special nursing care;
• Surgical care (inpatient services 100% covered after $250 hospital copay for faculty and staff; outpatient services 100% covered after $15 copay for bargaining unit employees ($30 specialist visits) and $20 copay ($35 copay for specialist visits for faculty and staff)), including:
  – Use of operating and recovery room;
  – Use of special procedure rooms;
  – Anesthesia services and supplies;
  – Diagnostic procedures, laboratory tests and x-ray services;
  – Drugs, medications, solutions, biological preparations and services associated with the administration of the same;
  – Medical and surgical supplies; and
  – Blood, blood plasma products and related donor processing fees that are not replaced by or on behalf of the patient (including infusions);
• Plan physicians’ and surgeons’ services, including consultation and treatment by specialists (specialist services 100% covered after $15 copay for bargaining unit employees)(specialist services 100% covered after $35 copay for faculty and staff);
• Chemotherapy and radiation therapy;
• Respiratory therapy;
• Medical social services and discharge planning;
• Urgent care: in-network urgent care is covered for life threatening or serious emergencies and subject to a copay of $50 (in network) for faculty and staff, and a $25 copay for bargaining unit employees;
• Emergency services require a $100 copay per hospital visit for faculty and staff; $50 copay for bargaining unit (waived if admitted); the $250 hospital copay will apply for faculty and staff; and
• Ambulance services if:
  – Your condition requires either the basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer; and
  – The ambulance transportation has been ordered by a primary care physician (coverage is also provided for Medically Necessary transportation or services rendered as the result of a 911 call).

**Mental Health and Substance Abuse Services**

Subject to all plan limits and provisions, covered mental health and substance abuse services include:

• Therapy prescribed or directed by a physician, including
  – Individual therapy;
  – Group therapy; and
  – Drug therapy.

• Psychiatric nursing care;

• Appropriate hospital services (medical services for detoxification are limited to the removal of the toxic substance or substances from the system);

• Outpatient services from physician or other health care professionals to treat mental illness, emotional disorders, drug abuse and alcohol abuse, including but not limited to:
  – Evaluations;
  – Crisis intervention;
  – Psychological and neuropsychological testing for diagnostic purposes;
  – Medical treatment for withdrawal symptoms; and
  – Visits for the purpose of monitoring drug therapy.

**Total Care and Cost Improvement**

Total Care and Cost Improvement (TCCI) is an umbrella program for qualified Members, aimed at providing improved quality of care by coordination of services, across provider type, setting and time, for those at high risk or with multiple chronic conditions. TCCI encompasses programs including, but not limited to, Health Promotion, Wellness and Disease Management Services Program (WDM), Hospital Transition of Care Program (HTC), Complex Case Management Program (CCM), Chronic Care Coordination Program (CCC), Behavioral Health and Substance Use Disorder Program (BSD), Home-Based Services Program (HBS), Enhanced Monitoring Program (EMP).

The vehicle for all care coordination efforts in the TCCI program array is the care plan. There are three TCCI programs that employ care plans: CCC, CCM and BSD. Essential to care coordination and case management is the Member’s consent to the creation, maintenance and faithful adherence to a care plan. Qualified Members who are compliant in their care plans may be eligible for a cost share waiver (i.e. copays, coinsurance, and deductibles) for services rendered outside of a hospital setting and during their participation in the program.
To learn more about the TCCI programs, you may call CareFirst at **877-691-5856**. You may also ask the Benefits Service Center for a copy of the Evidence of Coverage. Additional information can also be found on the CareFirst website here: [https://individual.carefirst.com/carefirst-resources/provider/pdf/pcmh-program-description-guidelines.pdf](https://individual.carefirst.com/carefirst-resources/provider/pdf/pcmh-program-description-guidelines.pdf).

### Other Covered Services

Home health care is generally covered in full.

Basic Durable Medical Equipment is generally covered in full. Durable Medical Equipment is defined as equipment that (1) is intended for repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) is generally not useful to a person in the absence of illness or injury, and (4) meets medical necessity criteria. **Please note:**

- Coverage is limited to the standard item of equipment that adequately meets your medical needs;
- Repairs or replacement of equipment is covered; and
- Diabetes equipment and supplies are separately covered.

Subject to all plan limits and provisions, the following other services are covered by the plan:

- Chiropractic services (covered services include spinal manipulation, limited to Medically Necessary spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine; limited to 30 visits per year; services limited to covered individuals 12 years of age or above);
- Diabetes equipment, diabetes supplies, and diabetes outpatient self-management training and education services, including medical nutrition therapy for:
  - Insulin-using diabetes;
  - Insulin-dependent diabetes;
  - Non-insulin using diabetes; and
  - Elevated blood glucose levels induced by pregnancy, including gestational diabetes.
- Diabetic equipment and supplies, when prescribed by a physician, including:
  - Insulin pump;
  - Blood/urine testing agents, including glucose test tablets, glucose test tape, glucose meters and acetone test tablets; and
  - Disposable needles and syringes in quantities needed for injecting prescribed insulin.
- Dialysis
  - Outpatient maintenance dialysis treatments in a dialysis facility (including the cost of laboratory tests, equipment, supplies and other services associated with your treatment);
  - Inpatient maintenance dialysis if you are admitted to a hospital because your medical condition requires specialized hospital services on an inpatient basis;
  - Physician services related to inpatient and outpatient dialysis;
  - Self-dialysis (training for self-dialysis at home, services of the provider who is conducting your self-dialysis training, retraining for use of new equipment for self-dialysis); and
  - Home dialysis (hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD)).
- Supplemental Durable Medical Equipment, when prescribed by a physician and your medical condition meets the criteria for medical necessity:
  - Oxygen and equipment;
  - Positive airway pressure equipment (continuous and bi-level);
  - Apnea monitors for infants under age three, for a period not to exceed six months;
  - Asthma equipment (spacers, peak-flow meters, nebulizers); and
- Billirubin lights for infants under age three, for a period not to exceed six months.

- Reproductive Health, including:
  - Pre- and post-natal care; and
  - Infertility services, which are limited to infertility counseling, testing and artificial insemination and in-vitro fertilization. Coverage for infertility services usually requires pre-authorization by the HMO; be sure to check with your primary care physician for requirements and limitations.

- Eye examinations for the diagnosis and treatment of a medical condition (annual routine eye examinations and eye refraction) ($10 copay for optometrist; $25 copay for ophthalmologist);

- Routine hearing screenings ($20 copay as part of a health assessment);

- Hearing aid coverage (minor children only);

- Rehabilitation services, including occupational therapy, physical therapy and speech therapy;

- Organ and tissue transplants, limited to the following procedures: kidney; cornea transplants; liver transplants for children with biliary artresia; autologous bone marrow or stem cell transplants that are not experimental or investigational; allogeneic bone marrow or stem cell transplants that are not experimental or investigational:
  - Immunosuppressant maintenance drugs;
  - Donor services not covered under any other health insurance plan or by any other source; and
  - Cost of hotel lodging and air transportation for the recipient and a companion (or two companions if the patient is under the age of 18 years) to and from the site of the transplant—only available if approved by the HMO and when the covered transplant is not performed in the service area.

- Maternity benefits, including maternity services (obstetrical care, prenatal, delivery, postnatal care; coverage for a hospital stay; coverage for care from approved licensed birthing center; collection of adequate samples for hereditary and metabolic newborn screening and follow-up; newborn hearing screening prior to discharge) and postpartum home visits (in accordance with the most current standards published by the American College of Obstetricians and Gynecologists);

- Birthing classes, one course per pregnancy at an approved facility;

- Surgical treatment of morbid obesity;

- Hair prosthetics resulting from chemotherapy and/or radiation therapy.

**Prescription Drug Benefits**

Express Scripts administers prescription drug benefits for the BlueChoice medical plan.

**What’s Not Covered**

The BlueChoice HMO does not cover the following services:

- Acupuncture, naturopathy and massage therapy, unless otherwise covered;

- Physical examinations and other services required for obtaining or maintaining employment or participation in employee programs, or required for insurance or licensing, or on court-order or required for parole or probation (this exclusion does not apply if the plan provider determines that the services are medically necessary);

- Cosmetic services that are intended primarily to improve your appearance and that will not result in significant improvement in physical function, except for services covered under reconstructive surgery, cleft lip or cleft palate or transgender services;

- Custodial care services (care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse, such as helping with walking, bathing, dressing, feeding, toileting and taking medicine);
• Dental care and dental x-rays, including dental appliances, dental implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any dental treatment involved in temporal mandibular joint (TMJ) pain dysfunction syndrome, unless otherwise covered (this exclusion does not apply to medically necessary dental care covered under accidental dental injury services, cleft-lip, cleft-palate or oral surgery);

• Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices;

• Durable Medical Equipment not listed as part of the covered services (including but not limited to: comfort, convenience or luxury equipment or features; exercise or hygiene equipment; non-medical items such as sauna baths or elevators; modifications to your home or car; or electronic monitors of the heart or lungs, except infant apnea monitors);

• Experimental or investigational services. A service is experimental or investigational for your condition if, at the time the service is or will be provided to you, any of the following apply:
  – The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted;
  – The service is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted;
  – The service is subject to the approval or review of an Institutional Review Board (IRB) of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
  – The service is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively:
  – Your medical records;
  – The written protocols or other documents pursuant to which the service has been or will be provided;
  – Any consent documents you or your representative has executed or will be asked to execute, to receive the service;
  – The files and records of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;
  – The published authoritative medical or scientific literature regarding the service, as applied to your illness or injury; and/or
  – Regulations, records, applications and any other documents or actions issued by, filed with or taken by the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

• Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids (except as otherwise provided for minor children);

• Payment of any claim, bill, or other demand or request for payment for covered services determined to be furnished as the result of a referral prohibited by law;

• Psychological and neuropsychological testing for ability, aptitude, intelligence or interest;

• Routine foot care services that are not medically necessary (this exclusion does not exclude services when you are under active treatment for a metabolic or peripheral vascular disease);

• Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation other than licensed ambulance, even if it is the only way to travel to a hospital or plan provider;
• Non-plan provider services provided or arranged by criminal justice institutions for Members in the
custody of law enforcement officers, unless the services are covered as out-of-plan emergency services.

Visiting Other Health Plan or Allied Plan Service Areas

If you visit a service area (different from your provider service area) temporarily — generally for no longer
than 90 days — you can receive visiting Member care from designated providers in that area. The covered
services, copayments, coinsurance, and deductibles may differ from those in your service area, and are
governed by the HMO program for visiting Members.

This visiting area program does not cover certain services, such as transplant services or infertility services.
Also, except for out-of-plan emergency services, your right to receive covered services in the visited service
area ends after 90 days unless you receive prior written authorization to continue receiving covered services
in the visited service area. The 90 day limit on visiting Member care does not apply to a covered child who is
out of area while attending an accredited college or accredited vocational school.

Service areas and facilities where you may obtain visiting Member care may change at any time.

Situations Affecting Your Health Care Coverage

If You Leave JHU

Your medical coverage ends on the last day of the month in which your employment ends. You may be able
to continue health care coverage for yourself and your dependents. Detailed information on continuation
coverage can be found under “Continued Coverage Under COBRA” in this section.

If You Qualify for Retiree Benefits

If your employment with JHU terminates, you and your dependents may be eligible for retiree health care
coverage under JHU’s Retiree Health Plan. See Chapter 10, “Medical and Dental Benefits for Retirees” for
eligibility requirements and other details.

If You Are on a Leave of Absence

If you elect to continue medical benefits while on an approved leave of absence, you must pay your share of
the premium on a monthly basis.

Dependent Coverage If You Die While a JHU Employee

Coverage for your covered dependents will continue until the end of the month in which you die. Your
dependents may be able to elect to continue coverage for a longer period. Detailed information on
continuation coverage can be found under “Continued Coverage Under COBRA” in this section.

If you die while an active employee and after meeting the eligibility requirements for retiree health benefits,
your dependents may be able to elect to continue coverage under JHU’s Retiree Health Plans.

If You Take Military Leave

If you take military leave that is covered by the Uniformed Services Employment and Reemployment Rights
Act of 1994 (USERRA), whether for active duty or for training, you are entitled to continue health coverage
for up to 24 months as long as you give JHU advance notice (with certain exceptions) of the leave, and
provided that your total leave, when added to any prior periods of military leave from JHU, does not exceed
five years (with certain exceptions). If the entire length of the leave is 30 days or less, you will not be required to pay any more than your regular contribution (if applicable) for coverage. If the entire length of the leave is 30 days or longer, you may be required to pay up to 102% of the entire cost of coverage (including JHU's contributions).

If you take military leave, but your coverage under the plan is terminated, for instance, because you do not elect the extended coverage, you will be treated as if you had not taken a military leave upon rehire when determining whether an exclusion or waiting period, if any, applies upon your reinstatement to the plan. (Exclusions may apply for services relating to an illness or injury that was incurred or aggravated during the period of uniformed service.)

USERRA continuation coverage counts as COBRA continuation coverage in any case where you are entitled to continue coverage under both laws and if you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage for the remainder of the 18 months.

If You Are Rehired

If you have been employed for one continuous year in a benefits eligible status, and your employment is terminated involuntarily due to reduction in force and you are rehired within 12 months, or if you voluntarily resign in good standing and are rehired within six months (but later than 30 days) following your termination, you will be eligible for the benefits associated with the new position. However, if you are rehired within 30 days of termination (and within the same Plan Year), all your previous benefit elections may be reinstated, including your flexible spending account elections. You can also make new elections upon rehire.

If you are rehired after a longer period than described above following your termination, you will be eligible for benefits as a new hire subject to any waiting period that applies to new hires. You should contact the Benefits Service Center regarding your benefit elections upon rehire.

Continued Coverage Under COBRA

This section of your Summary Plan Description applies to employees and covered spouses and covered children who have health coverage under the plan. Please note that COBRA applies only to the medical, prescription drug, dental and health care flexible spending account benefits described in this summary and not to any other type of benefit. In addition, please note that the information in this section does not apply to coverage provided for domestic partners or their children because, under federal law, COBRA does not apply to such coverage. However, JHU voluntarily offers similar continuation options for such coverage. See “COBRA-Like Rights of Domestic Partners and Their Children” for details.

COBRA continuation coverage is a temporary extension of coverage under the plan. This section of the Summary Plan Description generally explains COBRA continuation coverage, when it may become available, and what an individual needs to do to protect the right to receive it.

Please note: The following is only a summary of some of the important provisions of COBRA. If you experience a COBRA “qualifying event” and provide any required notice to the Plan Administrator by the applicable deadline, you will receive a COBRA Notice with additional information about COBRA.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to certain individuals when they would otherwise lose your group health coverage under certain circumstances. For additional information about your rights and obligations under the plan and under federal law, you should contact the Plan Administrator at the address provided in this notice.
What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health coverage under the plan when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” The covered employee, his/her covered spouse, and his/her dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Employees become qualified beneficiaries if they lose coverage under the plan because either one of the following qualifying events happens:

• The employee’s hours of employment are reduced; or
• The employee’s employment ends for any reason other than gross misconduct.

Spouses of employees will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

• The employee dies;
• The employee’s hours of employment are reduced;
• The employee’s employment ends for any reason other than his/her gross misconduct;
• The employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
• The employee and the spouse become divorced or legally separated.

An employee’s dependent children become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

• The parent-employee dies;
• The parent-employee’s hours of employment are reduced;
• The parent-employee’s employment ends for any reason other than his/her gross misconduct;
• The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
• The parents become divorced or legally separated; or
• The child stops being eligible for coverage under the plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to JHU, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

When is COBRA Coverage Available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.
The Individual Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), the individual must notify the Plan Administrator within 60 days after the later of (1) the date the qualifying event occurs, or (2) the date coverage would end because of the qualifying event. This notice must be provided, along with any required documentation to the Plan Administrator at the address noted in Chapter 11, “Administrative Information.”

The notice must be provided in writing in a letter addressed to the Plan Administrator. The notice must include:

- The individual’s name, address, phone number and health plan ID number;
- The name, address, phone number and health plan ID number for any dependent child or spouse whose eligibility is affected by the qualifying event;
- A description of the qualifying event and the date on which it occurred;
- The following statement: “By signing this letter, I certify that the qualifying event described in this letter occurred on the date described in this letter;” and
- The individual’s signature.

The individual providing the notice should also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date the divorce or legal separation began. If you have any question about what type of documentation is required, you should contact the Plan Administrator at the address provided in this notice.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, you may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. (Please note that the rest of this paragraph applies to health benefits other than a health care FSA. For the rules that apply to the health care FSA, see the “Special Rules for Health Care Flexible Spending Accounts” section below.) When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee’s divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his/her employment terminates, COBRA continuation coverage for his/her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended, as described in the next two sections.
Disability Extension of 18-Month Period of Continuation Coverage

If an employee, spouse or dependent child covered under the plan is determined by the Social Security Administration to be disabled before the 60th day of COBRA continuation coverage and that individual notifies the Plan Administrator in a timely fashion (following the same procedures described above under “The Individual Must Give Notice of Some Qualifying Events,” including providing documentation of the Social Security Administration’s decision), the individual and his/her entire covered family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The Plan Administrator reserves the right to terminate the disability extension if the Social Security Administration determines that the disabled qualified beneficiary is no longer disabled. Such notice shall be provided to the Plan Administrator within 60 days after the Social Security Administration’s determination and following the same procedures described above under “The Individual Must Give Notice of Some Qualifying Events”.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If a family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in the family can get up to an additional 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan (following the same procedures described above under “The Individual Must Give Notice of Some Qualifying Events”). This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

Special Rules for Health Care Flexible Spending Accounts

For a health care flexible spending account (“health care FSA”), COBRA continuation coverage is available only if the amount that a qualified beneficiary would be required to pay for the coverage for the remainder of the Plan Year is less than the amount of reimbursements that would be available to the qualified beneficiary if he or she elected COBRA coverage. Also, even if COBRA continuation coverage is available, it is available only for the remainder of the Plan Year in which the qualifying event occurs. COBRA continuation coverage for the health FSA cannot be extended beyond that time for any reason.

EXAMPLE: Assume that an employee elected to contribute a total of $1,200 to her health care FSA account for a Plan Year and then her employment terminates six months after the start of that Plan Year. By that time, she has contributed $600 to her FSA account through payroll deductions. Assume that she has already received $800 in reimbursements from her account for eligible expenses she paid before her employment terminated. In that case, the maximum benefit she could receive from her account for any eligible expenses she incurs for the rest of the Plan Year is $400. However, if she were permitted to continue to participate in the FSA for the rest of the Plan Year, she would be required to pay a total of $600 (plus about $12 in additional premiums allowed under COBRA) to continue that coverage. In that case, the amount she would be required to pay (about $612) is more than the maximum that she would be eligible to receive in reimbursements ($400), so she would not be offered COBRA continuation coverage under the FSA. On the other hand, if she had incurred expenses of $588 or less before her employment terminated, she would be offered the opportunity to elect COBRA continuation coverage under the FSA for the remainder of the Plan Year because her maximum benefit under the plan for the rest of the Plan Year would be more than the amount she would be required to pay ($612).

Any filing deadlines or other rules for filing a request for reimbursement under the health care FSA, as described earlier in this Summary Plan Description, will continue to apply if continuation coverage is elected under the health care FSA.
Trade Reform Act of 2002 and Trade Preferences Extension Act of 2015

The Trade Preferences Extension Act of 2015 has extended the Trade Reform Act of 2002, which created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a “trade readjustment allowance” or “alternative trade adjustment assistance.” These individuals can either take a tax credit or get advance payment of the applicable percentage of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act of 2002. However, this election may not be made more than six months after the date the individual’s group health plan coverage ends.

Your eligibility for subsidies under the Trade Preferences Extension Act of 2015 affects your eligibility for subsidies that provide premium assistance for coverage purchased through the Health Insurance Marketplace. For each coverage month, you must choose one or the other, and if you receive both during a tax year, the IRS will reconcile your eligibility for each subsidy through your individual tax return. You may wish to consult your individual tax advisor concerning the benefits of using one subsidy or the other.

Although it is unlikely that a JHU employee would qualify, you may contact the Benefits Service Center at 410-516-2000 for additional information or if you have any questions about these new provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 800-829-1040 or visit www.IRS.gov/HCTC. More information about the Trade Reform Act is also available at www.doleta.gov/tradeact.

Early Termination of Continuation Periods

In some cases, the COBRA continuation periods noted above terminate early. If you are eligible to elect COBRA, you will receive a COBRA Notice that includes details of COBRA early termination rules.

If You Have Questions

Questions concerning COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under COBRA contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Keep Your Plan Informed of Address Changes

To protect any rights your family may have under COBRA, you should keep the Plan Administrator informed of any changes in the addresses of you and your family members. You should also keep a copy, for your records, of any COBRA-related notices you send to the Plan Administrator.

**COBRA-Like Rights of Domestic Partners and Their Dependent Children**

The plan currently provides “COBRA-like” health care continuation benefits to covered domestic partners and covered dependent children of domestic partners under terms similar to those that apply to spouses and dependent children entitled to COBRA rights under federal law. domestic partners and covered children of domestic partners who believe they have experienced an event that gives rise to COBRA-like benefits are required to notify the Plan Administrator within 60 days of the date of that event in order to begin to enjoy these COBRA-like benefits. The termination of a domestic partnership will be treated like a divorce for
purposes of this continuation coverage provided that the employee and his/her former domestic partner provide adequate documentation (as determined for JHU) of the date of termination of the domestic partnership within the 60-day deadline.

For Other Information, Go To...

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<thead>
<tr>
<th>The Big Picture</th>
<th>For general information about JHU’s overall benefits program and how the myChoices Program works</th>
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<tbody>
<tr>
<td>Changes to Your Benefits</td>
<td>For information on how changes in family or work situations may affect your coverage</td>
</tr>
<tr>
<td>Administrative Information</td>
<td>For important facts about health care plan administration, and your rights under ERISA</td>
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</table>
Chapter 4 – Dental Plan

FAST FACTS

• You have three options for dental coverage.
  – Two preferred provider organization (PPO) plans
    ▪ CareFirst BlueCross BlueShield
    ▪ CIGNA; and
  – A dental health maintenance organization (DHMO)
    ▪ United Concordia ConcordiaPLUS®.

JHU’s health coverage offers several dental plan options covering a range of services and procedures including exams and cleanings, fillings, x-rays, oral surgery, dentures and orthodontics.

Each of the three JHU dental plans offers a choice of network and, in some cases, non-network providers for dental services. The cost of your care depends on your choice of provider and the type of service rendered.

CareFirst BlueCross BlueShield and CIGNA dental plans operate as preferred provider organization (PPO) plans. Network “preferred providers” under these plans have agreed to provide service at a lower cost to you than non-preferred providers. Preferred providers are considered to be “in network” and non-preferred providers are “out of network.” If you enroll in CareFirst BlueCross BlueShield, you will receive a membership card. If you enroll in CIGNA, no membership card is issued.

United Concordia ConcordiaPLUS operates similar to a health maintenance organization (HMO). This plan has a network of participating dental offices. The cost of services provided is based on a negotiated fee with the plan provider. You must select a primary dental office (PDO) for you and all your dependents. Each family member may select a different PDO. If you do not select a PDO, one will be assigned to you. To find a PDO, visit the Concordia website at www.unitedconcordia.com or call customer service at 866-357-3304. You may change your PDO at any time by calling customer service; changes take effect the first day of the month after you notify customer service. Any service received outside of your approved PDO is not covered. If you enroll in this plan, you will receive a membership card.

What’s Covered

Dental coverage under the JHU options is divided into four categories of service (called “Classes”), generally described as Preventive, Basic, Major and Orthodontia. The cost of covered services varies for each Class and for the type of dental provider you see (in network or out of network). Refer to the next table for the coverage amounts for each option and for each Class.
### Benefits At-A-Glance

The table below is an overview of covered services. Any limitations or exclusions for services are listed in the “Limitations and Exclusions” section of this chapter.

<table>
<thead>
<tr>
<th>CAREFIRST BLUECROSS BLUESHIELD DENTAL PLAN</th>
<th>CIGNA DENTAL PLAN</th>
<th>UNITED CONCORDIA PLUS DENTAL PLAN</th>
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<tr>
<td><strong>Calendar Year Deductible</strong></td>
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<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
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<thead>
<tr>
<th>Class I Diagnostic &amp; Preventive Services: cleanings, x-rays, office visits (no deductible applies)</th>
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<tr>
<td>100% of allowable charges.</td>
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<td>100% of allowable charges.</td>
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<tr>
<th>Class II Basic Services: fillings, root canals, periodontics, oral surgery</th>
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<tr>
<td>75% of allowable charges.</td>
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<tr>
<td>75% of allowable charges, subject to deductible.</td>
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<td>75%</td>
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<tr>
<td>75% subject to deductible.</td>
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<tr>
<td>90-100% (fillings) 70% (basic)</td>
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<th>Class III Major services: dentures, crowns &amp; bridges</th>
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<td>50% of allowable charges.</td>
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<tr>
<td>50% of allowable charges, subject to deductible.</td>
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<td>50%</td>
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<td>50%, subject to deductible.</td>
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<td>70%</td>
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<tr>
<th>Class I, II &amp; III Calendar Year Maximum Benefit</th>
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<td>$1,500 combined total for in-network and out-of-network providers.</td>
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<tr>
<td>$1,500 combined total for in-network and out-of-network providers.</td>
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<tr>
<td>No maximum.</td>
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<tr>
<th>Class IV Orthodontics</th>
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<tr>
<td>50% of allowable charges.</td>
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<td>50% of allowable charges.</td>
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<tr>
<td>50%</td>
</tr>
<tr>
<td>Participant pays scheduled copay.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lifetime Maximum Benefit (Class IV only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,500 total for in-network and out-of-network orthodontic services.</td>
</tr>
<tr>
<td>$1,500 total for in-network and out-of-network orthodontic services.</td>
</tr>
<tr>
<td>No maximum.</td>
</tr>
</tbody>
</table>

Please note: “Allowable charges” are the negotiated fee that is determined to be reasonable and customary by the insurance company. ConcordiaPLUS is a dental maintenance plan (DHMO) offered by United Concordia and it pays benefits on a fixed schedule. For comparison purposes, the amounts have been converted to percentages for use in this chart only.

### Class I: Preventive & Diagnostic Services

Subject to the limitations and provisions of the plan, the following preventive and diagnostic services are covered by the JHU dental options. Coverage amounts vary by option, dental provider and type of service. Refer to the Benefits-At-A-Glance chart in this chapter for coverage amounts. A summary of covered preventive and diagnostic services for each option is listed below.
CareFirst BlueCross BlueShield

**Twice per Calendar Year**
- Oral exam;
- Bitewing x-rays (not occurring at same time as full mouth or panograph x-rays);
- Routine cleaning (except when diagnosed with periodontal disease, two (2) additional cleanings);
- Topical fluoride; and/or
- Pulp vitality tests.

**Once per 36 Months**
- One set of full mouth x-rays or one panograph x-ray and one additional set of bitewing x-rays;
- One cephalometric x-ray or periapical and occlusal x-ray; and/or
- One sealant per tooth on permanent molars.

**Once per 60 Months**
- Space maintainers (prematurely lost cuspid to posterior deciduous teeth).

**As Required**
- Palliative treatments;
- Emergency oral exam;
- Histopathology exams and other oral pathology procedures by report;
- Periapical and occlusal x-rays; and/or
- Professional consultation rendered by a dentist, limited to one consultation per dentist per condition.

CIGNA

**Twice per Calendar Year**
- Oral exam;
- Bitewing x-rays; and/or
- Routine cleaning.

**Once per Calendar Year**
- Topical fluoride, excludes prophylaxis (until age 19).

**Once per Three Calendar Years**
- Complete series of x-rays, including panoramic; and/or
- Topical application of sealant per tooth (until age 14).

**As Required**
- Periodontal maintenance procedures (following active therapy, two per calendar year); periodontal prophylaxis;
- Space maintainers, fixed unilateral (limited to non-orthodontic treatment); and/or
- Emergency treatment of dental pain.
United Concordia ConcordiaPLUS

Covered Services
• Oral exam;
• Routine x-rays;
• Routine cleaning (two per calendar year);
• Topical fluoride;
• Periodontal maintenance (two per calendar year);
• Space maintainers (until age 18);
• Sealants are eligible for members to age 16 on permanent first and second molars;
• Pulpal therapy (age 5 on one degree anterior teeth, age 11 on one degree posterior teeth); and/or
• Emergency care (if within 50 miles of your home, an applicable copay may apply).

Class II: Basic and Restorative Services

Subject to the limitations and provisions of the plan, the following basic and restorative services are covered by the JHU dental options. Coverage amounts vary by option, dental provider and type of service. Refer to the Benefits-At-A-Glance chart in this chapter for coverage amounts. A summary of covered basic and restorative services for each option is listed below.

CareFirst BlueCross BlueShield

Primary Maintenance Services
• Direct placement fillings, including direct pulp caps, limited to silver amalgam, silicate, plastic, composite, or equivalent material approved by CareFirst;
• Services as required:
  – Root tip removal;
  – Pulpotomy for deciduous teeth;
  – Root canal for permanent teeth;
  – Root canal retreatment performed on permanent teeth limited to once per tooth per lifetime;
  – Root resection;
  – Other endodontics;
  – Repair of removable dentures;
  – Recementation of crowns, inlays and/or bridges;
  – Stainless steel crowns; and/or
  – Visits by a dentist to your home when medically necessary to render a covered dental service.

Primary Oral Surgical Services
• Services as required:
  – Surgical extractions, including impactions;
  – Oral surgery, including treatment for cysts, tumors and abscesses;
  – Oral surgery performed for the preparation of the mouth for dentures;
  – Biopsies of oral tissue if a biopsy report is submitted;
  – General anesthesia and or intravenous sedation, if required for oral surgery and administered by a dentist who has a permit to administer conscious sedation or general anesthesia;
– Apicoectomy; and/or
– Hemi-section.

**Primary Periodontic Services**
- Services limited to once per 24 months, one full mouth treatment:
  – Periodontal scaling and root planing; and/or
  – Gingival curettage.
- Services limited to once per 60 months:
  – Osseous surgery, including flap entry and closure (one full mouth treatment); and/or
  – Gingivectomy (one full mouth treatment).
- Limited or complete occlusal adjustments in connection with periodontal treatment; and/or
- Mucogingival surgery limited to grafts and plastic procedures; one treatment per site.

**CIGNA**

**As Required**
- Fillings;
- Root canal;
- Simple extractions;
- Surgical extractions;
- Osseous surgery;
- Periodontal scaling and root planing;
- Denture adjustments; and/or
- Recement bridges.

**United Concordia ConcordiaPLUS**

**Covered Services**
- Fillings;
- Root canal (one per tooth, per lifetime);
- Simple extractions;
- Periodontal scaling and root planing (one per 24 months); and/or
- Other services - per schedule.

**Class III: Major Services**

Subject to the limitations and provisions of the plan, the following major services are covered by the JHU dental options. Coverage amounts vary by option, dental provider and type of service. Refer to the Benefits-At-A-Glance chart in this chapter for coverage amounts. A summary of covered major services for each option is listed below.
CareFirst BlueCross BlueShield

Covered Services

• Services limited to 60 months:
  – Dentures, full and/or partial;
  – Fixed bridges, including crowns, inlays and onlays used as abutments for or as a unit of the bridge; and/or
  – Crowns, inlays or onlays.
• Denture adjustments and relining limited to:
  – “Regular” dentures: once per 36 months, but not within six months of initial placement;
  – “Immediate” dentures:
    – Initial adjustment/relining after three months of placement;
    – Second adjustment/relining within the first 12 months; and
    – Third adjustment/relining 36 months thereafter.
• Repairs of fixed bridge; and/or
• Prosthetic services.

CIGNA

As Required

• Bridges;
• Crowns;
• Full and partial dentures; and/or
• Prosthesis over implants (a prosthetic device, supported by an implant or implant abutment is a covered expense). Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least five calendar years old, is not serviceable and cannot be repaired.

United Concordia ConcordiaPLUS

One per Five Years

• Full and partial dentures; and/or
• Other services - per schedule.

One per Tooth per Five Years

• Bridges;
• Crowns;
• Inlays and onlays;
• Buildups;
• Posts; and/or
• Cores.
**Class IV: Orthodontia**

Subject to the limitations and provisions of the plan, the following orthodontic services are covered by the JHU dental options. Coverage amounts vary by option, dental provider, and type of service. Refer to the Benefits-At-A-Glance chart for coverage amounts. A summary of covered orthodontic services for each option is listed below.

**CareFirst BlueCross BlueShield**

Benefits for orthodontic services will be available to all Members.

**Covered Benefits**

- The first and later installments of orthodontic services; and/or
- All orthodontic services that reduce or eliminate an existing malocclusion and associated oral diseases.

**Limitation**

The length of time for orthodontic services treatment shall be no more than 36 consecutive months of covered services.

**CIGNA**

- The first month of active treatment including orthodontic work-up (x-rays, diagnostic casts, treatment plan and retention appliance);
- Continued active treatment after the first month; and/or
- One appliance (fixed or removable) for either tooth guidance or to control harmful habits.

**United Concordia ConcordiaPLUS**

- Adults and children covered;
- Limited orthodontic treatment;
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (two year treatment); and/or
- All services - per schedule.

**Limitations on Coverage**

The following limitations apply to services covered by the JHU dental options.

**CareFirst BlueCross BlueShield**

The following are the limitations on coverage by CareFirst BlueCross BlueShield:

- Covered dental services must be performed by or under the supervision of a dentist, within the scope of practice for which licensure or certification has been obtained;
- Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures or bridges, including precision attachments and custom denture teeth;
- If you switch from one dentist to another during the course of treatment, or if more than one dentist renders services for one dental procedure, CareFirst shall pay as if only one dentist rendered the service;
• CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to orthodontic services); and
• In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for your condition, benefits will be based upon the lowest cost alternative.

**CIGNA**

Under the CIGNA Plan, no payment will be made for expenses incurred for you or any of your dependents:

• For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
• For or in connection with a sickness which is covered under any workers’ compensation or similar laws;
• For charges made by a hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military-service-connected condition;
• Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
• To the extent that payment is unlawful where the person resides when the expenses are incurred;
• For charges which the person is not legally required to pay;
• For charges which would not have been made if the person had no insurance;
• To the extent that billed charges exceed the rate of reimbursement as described in the Benefits-At-A-Glance chart;
• For charges for unnecessary care, treatment or surgery;
• To the extent that you or your dependents are in any way paid or entitled to payment for those expenses through a public program, other than Medicaid; or
• For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

**United Concordia ConcordiaPLUS**

Under the United Concordia ConcordiaPLUS Plan, the following rules apply:

• Referrals to specialty care dentists are limited to orthodontics, oral surgery, periodontics, endodontics and pediatrics;
• Coverage for referral to a pediatric specialty care dentist terminates on the 7th birthday. Exceptions are made for physical or mental handicaps or medically compromised children, when confirmed by a physician, and may be considered on an individual basis with prior approval;
• Coverage for dependent children ends at age 26;
• Oral surgery services are limited to surgical exposure of teeth, removal of teeth, preparation of the mouth for dentures, removal of tooth generated cysts, frenectomy and crown lengthening;
• If a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist, an alternate benefit provision (ABP) may be applied. The ABP does not, however, commit you to the less costly treatment. If you and the dentist choose the more expensive treatment, you are responsible for the additional charges beyond those allowed for the ABP;
• If an emergency occurs more than 50 miles from home, you are covered up to $50 per visit to see a non-PDO dentist; and/or
• Restorations, crowns, inlays, and onlays are covered only if necessary to treat diseased or accidentally fractured teeth, as determined by the dental director.
**Exclusions**

**General Exclusions**

JHU's dental options do not provide coverage for the following services:

- Any services not listed in the coverage descriptions under each class of service;
- Dental services performed for cosmetic reasons;
- Surgical implant, including any prosthetic device attached to it;
- Replacement of a lost, missing, or stolen appliance (such as an orthodontic retainer, headgear or removable partial or full denture);
- Replacement of dentures, bridges, or crowns that are serviceable, usable or repairable by common dental standards;
- Services or appliances that alter the vertical dimension;
- Treatment or services for temporal mandibular joint (TMJ);
- Splinting;
- Any experimental procedures or treatment methods;
- Dental care that does not meet accepted standards of dental treatment; or
- Services not deemed necessary by the caregiver.

Other services not covered by dental options are plan-specific, as described in the following sections.

**CareFirst BlueCross BlueShield**

In addition to the general exclusions, the following services are not covered under the CareFirst BlueCross BlueShield option:

- Replacement of dentures, bridges, or crowns within five years from the date of replacement or replacement for which benefits were paid in whole or in part under the terms of Class III coverage;
- The repair or replacement of any orthodontic appliance;
- Any orthodontic service after the last day of the month in which covered services end;
- Orthognathic surgery;
- Gold foil fillings;
- Periodontal appliances;
- Services received from a provider who is a relative of the patient or is not a health care practitioner;
- Prescription drugs;
- Orthognathic surgery or other oral surgery covered under the medical plan;
- Nightguards, occlusal guards, or other oral orthotic appliances;
- Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed elsewhere in this document as a covered dental service;
- Intentional tooth reimplantation or transplantation;
- Additional fees charged for visits by a dentist to your home, to a hospital, to a nursing home, or for office visits after the dentist’s standard office hours; CareFirst shall provide the benefits for the dental service as if the visit was rendered in the dentist's office during normal office hours;
- Transseptal fiberotomy or vestibuloplasty; or
• Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be a covered dental service).

**CIGNA**

In addition to the general exclusions, the following services are not covered under the CIGNA dental option:

• Replacement of a bridge, crown or denture within five years after the date it was originally installed unless:
  – Such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or
  – The bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is covered under the plan.

• Procedures, appliances or restorations (except full dentures) whose main purpose is to stabilize periodontally involved teeth or restore occlusion;

• Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;

• Bite registrations;

• Precision or semi precision attachments;

• Instruction for plaque control, oral hygiene and diet;

• Services that do not meet common dental standards or are deemed to be medical services; and

• Services and supplies received from a hospital.

**United Concordia ConcordiaPLUS**

In addition to the general exclusions, the following services are not covered under the United Concordia ConcordiaPLUS dental option:

• Services, supplies or charges provided by out-of-network dentists unless preauthorized, except when immediate dental treatment is required as a result of a dental emergency occurring more than 50 miles from your home;

• Dental services necessary due to patient neglect, lack of cooperation with the PDO or failure to comply with a professionally prescribed treatment plan;

• Dental services that began prior to your coverage under the option or started after the termination date of coverage;

• Services received in and associated with a hospital;

• Services determined to be the responsibility of workers’ compensation, a health care plan or payable under any federal government or state program;

• Administration of oral sedation, nitrous oxide, general anesthesia or intravenous sedation not specifically provided under the option;

• For congenital mouth malformations or skeletal imbalances;

• Repair of an orthodontic appliance;

• Prosthetic reconstruction or other services which require a prosthodontist;

• Active orthodontic treatment that began prior to your coverage under the option;

• Broken appointments;

• Services as the result of voluntary self-inflicted injury or illness whether the patient is sane or insane;

• House calls;
• Prescription or nonprescription drugs, vitamins or dietary supplements;
• Any dental or medical services performed by a physician and/or services which are otherwise provided under a health care plan;
• Training and/or appliance to correct or control harmful habits;
• Duplicate dentures, prosthetic devices or any other duplicate appliance;
• Services required because of, or in connection with, acts of war, declared or undeclared;
• Elective procedures, including prophylactic extraction of third molars;
• Retreatment of orthodontic cases and changes in orthodontic treatment necessitated by patient neglect; and
• An assistant dental surgeon.

**Predetermination of Benefits**

CareFirst and CIGNA suggest you obtain predetermination of benefits prior to extensive proposed and/or planned work (e.g., work that could exceed $300). Predetermination lets you know whether the service is covered and if the amount would be paid by the plan.

**CareFirst BlueCross BlueShield**

**Estimate of Eligible Benefits**

A dentist may propose a planned dental treatment or series of dental procedures. You may choose to obtain a written estimate of the benefits available for the planned treatment or procedure(s).

You are encouraged to obtain a written Estimate of Eligible Benefits for major dental procedures before service is rendered. You will then be alerted about out-of-pocket expenses that may be associated with the treatment plan and/or procedures that are considered non-covered services. Based on an Estimate of Eligible Benefits, you can decide whether or not to incur any expense associated with your dental treatment.

Failure to obtain an Estimate of Eligible Benefits has no effect on the benefits you are entitled to under this contract. You may choose to forgo the Estimate of Eligible Benefits and proceed with treatment.

After services are rendered, the claim will be reviewed by CareFirst. If the review determines that services rendered meet the criteria for benefits, coverage will be provided. However, if the review of the claim determines that the treatment or procedure does not meet the criteria for benefits, coverage will not be provided for that treatment or procedure.

To request an Estimate of Eligible Benefits prior to receiving dental treatment or dental procedures, contact your dentist who will then coordinate the request on your behalf.

If your dentist has any questions about the process, he or she may contact the CareFirst Provider Services Department. The Estimate of Eligible Benefits is merely an estimate, and cannot be considered a guarantee of your benefits or enrollment under this contract.

**CIGNA**

**Predetermination of Benefits**

Following a submission of a dentist’s description of planned treatment and expected charges, CIGNA will advise you of the covered services and your out-of-pocket costs. CIGNA will advise you if an Alternate Benefit Provision (ABP) is applicable. An ABP applies when more than one dental service can provide
treatment based on common dental standards. If you and your dentist choose a more costly treatment, you are responsible for additional charges beyond those allowed for the ABP.

United Concordia ConcordiaPLUS

Pre-Treatment Review

If extensive dental work is proposed or planned, it is recommended that you find out in advance what the dental option will pay before you undergo costly dental treatment. This is called pre-treatment review. Generally, pre-treatment review is recommended when your dentist proposes dental treatment that will cost $300 or more (or otherwise specified by the dental option), or coverage for any proposed procedure is in question.

Services In-progress When Coverage Ends

CareFirst BlueCross BlueShield

Services are covered for at least 90 days after your termination date if either of the following is true:

- The service began before the date your coverage terminates; and
- Two or more visits are required — on separate days — to a dentist’s office to complete the service. (This does not apply to orthodontic services.)

Orthodontic services will be covered for 60 days after your termination date if the orthodontist agrees to receive payment either monthly or quarterly.

CIGNA

Otherwise eligible expenses are covered for a dental procedure that is completed after your benefits cease and will be deemed to be incurred while you are insured if:

- For fixed bridgework and full or partial dentures, the first impressions were taken and/or abutment teeth fully prepared while you were insured and the device is installed or delivered within three calendar months after your coverage ends;
- For a crown, inlay or onlay, the tooth was prepared while you were covered and the crown, inlay or onlay is installed within three calendar months after your coverage ends; or
- For root canal therapy, the pulp chamber of the tooth is opened while you are covered and a treatment is completed within three calendar months after your coverage ends.

There are no additional extensions for any dental services.

United Concordia ConcordiaPLUS

Orthodontic services will continue for 60 days after your coverage terminates if the following is true:

- Either services are paid monthly, or
- At the end of the quarter in progress, if paid quarterly.
**Dental Services Covered Under the Medical Plan**

Services which are covered under your JHU medical plan option are not eligible for dental coverage.

**Filing Dental Claims**

You must file claims for out-of-network care under both the CIGNA and CareFirst BlueCross BlueShield dental options. For in-network care, your dental provider will complete and submit the claim forms. No claim forms are required for covered services under the United Concordia ConcordiaPLUS® option.

**For Other Information, Go To...**

<table>
<thead>
<tr>
<th>The Big Picture</th>
<th>For general information about JHU's overall benefits program and how the myChoices Program works</th>
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<tbody>
<tr>
<td>Changes to Your Benefits</td>
<td>For information on how changes in family or work situations may affect your coverage</td>
</tr>
<tr>
<td>Administrative Information</td>
<td>For important facts about health care plan administration, and your rights under ERISA</td>
</tr>
</tbody>
</table>
Chapter 5 – Flexible Spending Accounts (FSAs)

**FAST FACTS**

JHU offers two FSAs:
- Health care flexible spending account; and
- Dependent care flexible spending account.

You can save money on eligible health care and dependent care expenses when you use the JHU flexible spending accounts (FSAs).

You can contribute up to $2,650 a year on a before-tax basis to pay for eligible health care expenses and up to $5,000 a year ($2,500 if you’re married and you and your spouse file separate tax returns) on a before-tax basis to pay for eligible dependent care expenses.

Remember to plan carefully—if you do, you’ll be able to maximize your tax savings without forfeiting any unused funds that remain in your account.

FSAs offer a way to help you save money on your eligible out-of-pocket health care and dependent care expenses by letting you pay for these eligible expenses with tax-free dollars. Here’s a quick summary of how the FSAs work:
- You choose how much you want to contribute to each account for the calendar year;
- Your contributions are taken out of your pay on a before-tax basis (for federal and Maryland tax purposes); and
- During the year, to pay for eligible expenses you may draw money from your FSA using:
  - A WageWorks reimbursement card (for health care expenses only);
  - The Pay My Provider service;
  - Online bill pay; or
  - Traditional claims reimbursement.
- Up to $500 in unused health care FSA contributions will automatically be carried over to the next calendar year and can be applied to eligible expenses in that year.

With savings of up to 35% or even more (depending on your tax bracket), when you use the spending account to be reimbursed for eligible expenses, it’s like buying these items and services “on sale.”
Benefits At-A-Glance

The following chart provides an overview of the features of the flexible spending accounts (FSAs).

<table>
<thead>
<tr>
<th>Flexible Spending Accounts</th>
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<tbody>
<tr>
<td><strong>Health Care Flexible Spending Account</strong></td>
<td><strong>Dependent Care Flexible Spending Account</strong></td>
</tr>
<tr>
<td><strong>Why Participate</strong></td>
<td>To save on taxes by paying for eligible expenses with before-tax dollars.</td>
</tr>
<tr>
<td><strong>What’s Reimbursed?</strong></td>
<td>Out-of-pocket health care expenses not reimbursed by your health care plans and considered deductible by the IRS. For example:</td>
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<tr>
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<td>• Medical and dental plan deductibles, co-insurance and copayments;</td>
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<td>• Prescription eyeglasses and hearing aids; and/or</td>
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<td></td>
<td>• Orthodontic expenses.</td>
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<td></td>
<td>Eligible expenses to care for your children under age 13 (or a disabled dependent of any age), so that you and your spouse can work. For example:</td>
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<td></td>
<td>• Nursery school or day care for children;</td>
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<td></td>
<td>• After-school programs for children under age 13; and/or</td>
</tr>
<tr>
<td></td>
<td>• Day care for a disabled spouse or parent.</td>
</tr>
<tr>
<td><strong>How Much You Can Contribute</strong></td>
<td>Up to $2,600 each year.</td>
</tr>
<tr>
<td></td>
<td>Up to $5,000 each year ($2,500 if you are married and you and your spouse file separate tax returns).</td>
</tr>
<tr>
<td><strong>Additional Information</strong></td>
<td>Up to $500 in unused health care FSA contributions will automatically be carried over to the next calendar year and can be applied to eligible expenses in that year.</td>
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<tr>
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<td>The deadline for filing claims for expenses incurred during the calendar year is April 30 of the following year; and</td>
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<td>If you are an active participant on December 31, you may be reimbursed under that year’s account for eligible claims incurred through December 31.</td>
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Participating in Flexible Spending Accounts

How the FSAs Work

Make Your Enrollment Decision

During the annual enrollment period (or when you first become eligible), you decide whether to participate and, if so, how much money you want to contribute for the coming year. You may participate in one account or both accounts, or you may elect not to participate in either.
Carefully estimate expenses for the year before you decide how much to contribute. Throughout the year, JHU deducts contributions from your pay in equal amounts each pay period before FICA (Social Security and Medicare taxes); federal and Maryland income taxes are deducted.

**Pay Your Expenses**

When you pay an eligible expense, save your receipt, regardless of whether you are using a WageWorks reimbursement card (issued to you when you enroll in a health care FSA), the Pay My Provider service, online bill payment or traditional claims reimbursement.

**File Claims**

File a claim to be reimbursed for your out-of-pocket expenses not paid using your WageWorks reimbursement card or Pay My Provider service. Expenses paid with the WageWorks reimbursement card and using Pay My Provider are paid directly from your FSA.

**Receive Tax-Free Reimbursement**

For claims reimbursements paid to you, once your claim is approved, you may have a check mailed to you or you may elect direct deposit of your FSA reimbursements into your checking or savings account. These reimbursements are tax-free to you.

**Election Applies for Calendar Year**

When you elect to participate in the health care or dependent care FSA, your election applies to the calendar year. If you make your election during annual enrollment in the fall, your election is effective for the upcoming calendar year. If you are a new hire or making a change to your election because of a life event, your election is effective for the remainder of the current calendar year only. Changes during the year are allowed only if you experience certain qualifying events. See “Qualifying Events” in Chapter 1, “The Big Picture” for more information.

**Estimate Carefully**

You will want to carefully estimate the expenses you expect to claim through each FSA for the calendar year because you may forfeit money you contribute to an FSA but don’t use for eligible expenses. Up to $500 in unused health care FSA contributions will automatically be carried over to the next calendar year and can be applied to eligible expenses in that year. The carryover amount does not require an election amount or any payroll deduction and will be deposited into your health care FSA on May 15 every year. Claims will first be paid from the current plan years’ balance and then deducted from any carryover amounts.

You must enroll for the FSAs during annual enrollment, even if you participated in the prior year. That is, you must make new elections to your FSAs each annual enrollment, even if you want the same elections you made the prior year.

Additional IRS rules require you to:

- Keep the money you contribute to each account separate. You cannot transfer money between the health care and dependent care FSAs or use amounts contributed to one account to pay for expenses reimbursable through the other account.
- Make one election for the year. Once you enroll, your decisions generally remain fixed until the next calendar year. However, you may make changes within 30 days of certain qualifying events. See “Qualifying Events” in Chapter 1, “The Big Picture,” for more information.
- Choose to continue or stop health care FSA contributions while on Family and Medical Leave. If you take Family and Medical Leave, you may stop your health care FSA contributions upon your leave (or you may...
continue to make contributions on an after-tax basis, if necessary). If you return from unpaid leave lasting greater than 30 days and did not elect to make health care FSA contributions during your leave through COBRA, you must re-enroll to participate in the health care FSA. (Participation in the dependent care FSA stops while you are on Family and Medical Leave but you may elect to re-enroll upon your return to work.)

• Provide information with your claims. Review how to file for reimbursement for the health care FSA and dependent care FSA.

Please note: Employees who are called to perform active military service for more than 179 days may request a taxable cash distribution of their unused health care FSA balances before the Plan Year ends. Contact the Benefits Service Center for more information.

Special Qualifying Event Rules for the Health Care FSA

The “Qualifying Events” information in Chapter 1, “The Big Picture,” describes certain qualifying events that may allow you to change your myChoices Program elections during the year.

In Real Life

An example of an FSA savings situation:

Jean is married, earns $40,000 a year, and has two children. Her husband also earns $40,000 a year. They file a joint tax return each year. During annual enrollment, Jean elects to contribute $1,000 to the health care FSA to help pay for her family’s eligible health care costs next year. She also elects to participate in the dependent care FSA by contributing $5,000 to help pay the costs of day care for her children. Here’s how Jean saves by using the FSAs. (Please note: The example does not consider child care tax credits that may be available.)

<table>
<thead>
<tr>
<th></th>
<th>Without Flexible Spending Accounts</th>
<th>With Flexible Spending Accounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined annual income</td>
<td>$80,000</td>
<td>$80,000</td>
</tr>
<tr>
<td>Health care contribution</td>
<td>$0</td>
<td>$1,000</td>
</tr>
<tr>
<td>Dependent care contribution</td>
<td>$0</td>
<td>$5,000</td>
</tr>
<tr>
<td>Adjusted gross income</td>
<td>$80,000</td>
<td>$74,000</td>
</tr>
<tr>
<td>Estimated taxes*</td>
<td>$24,000</td>
<td>$22,200</td>
</tr>
<tr>
<td>Health care expenses</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Dependent care expenses</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Reimbursement from:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health care account</td>
<td>$0</td>
<td>+ 1,000</td>
</tr>
<tr>
<td>Dependent care account</td>
<td>$0</td>
<td>+ 5,000</td>
</tr>
<tr>
<td>Net annual income</td>
<td>$50,000</td>
<td>$51,800</td>
</tr>
<tr>
<td>Annual savings</td>
<td>$1800</td>
<td></td>
</tr>
</tbody>
</table>

* Assumes Jean and her husband file jointly and pay 30% of their income in federal, Maryland and FICA taxes.

Your actual tax savings will depend on your FSA contributions and your personal tax situation. Please consult with your tax advisor for details.
**Health Care Flexible Spending Account**

**How Much You Can Contribute**

You may contribute up to $2,650 in 2018 to a health care FSA. The amount you elect will be deducted in equal contributions from your paycheck during the year.

**Eligible Health Care Expenses**

Generally, any health care expense considered by the IRS as an expense for “medical care” (other than insurance premiums) is eligible for reimbursement from your health care FSA, provided the expense is not reimbursed from any other source. This includes health care expenses for anyone you claim as a dependent on your tax return, regardless of whether that dependent is covered under JHU’s group health plan as well as eligible health care expenses of your biological, adopted or stepchild who will be under age 27 on the last day of the calendar year in which the expense is incurred.

*Please note: Domestic partners and their children are eligible for coverage under JHU’s medical and dental plans. However, under federal tax law, a health care FSA may not be used for expenses of domestic partners or their children, unless they qualify as your eligible dependent under the specific federal tax law definitions that apply to health care FSAs.*

In addition to deductibles and copayments, the following is a partial list of medical expenses that are generally eligible for reimbursement from your health care FSA (under current IRS guidelines, which are subject to change).

Additional medical necessity documentation may be required for some items, which are listed on the following page.
| Acupuncture | Fees for a practical nurse |
| Alcoholism treatment | Handicapped persons' special schools |
| Artificial teeth | Hearing devices and batteries |
| Birth control pills | Home improvements for medical considerations |
| Braces | Hospital bills |
| Chiropractors | Hypnosis for treatment of an illness |
| Coinsurance amounts you pay | Insulin |
| Contact lenses and solution | Laboratory fees |
| Cost of operations and related treatments | Learning disability |
| Crutches | Life fee to retirement home for medical care |
| Deductible amounts you pay | Medical charges, other than insurance premiums, if they are separately specified as part of college or private school tuition fees |
| Dental fees | Nursing home |
| Dentures diagnostic fees | Orthopedic shoes |
| Prescribed drugs and medicines | Over-the-counter medications (only when prescribed) |
| Eyeglasses, including examination fees | Oxygen |
| Eye surgery, including laser correction eye surgery | Physicians’ fees |
| | Psychiatric care |
| | Psychologists' fees |
| | Smoking cessation programs (only when under doctor supervision and with prescribed medication) |
| | Special plumbing for the handicapped |
| | Sterilization fees |
| | Surgical fees |
| | Therapeutic care for drug and alcohol addiction |
| | Therapy treatments |
| | Transplants |
| | Transportation expenses primarily for rendering medical services |
| | Weight loss programs (undertaken at a physician’s direction to treat an existing disease, including obesity) |
| | Wheelchairs |
| | X-rays |

Under current federal law, only medicines and drugs obtained by prescription will be reimbursable from a health care FSA. The only exception is insulin, which is reimbursed without a prescription.
The following is a partial list of health care expenses that are not eligible for reimbursement from your health care FSA:

<table>
<thead>
<tr>
<th>Flexible Spending Accounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childbirth preparation classes for “coach”</td>
</tr>
<tr>
<td>Cosmetic dentistry</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
</tr>
<tr>
<td>Dancing/swimming lessons</td>
</tr>
<tr>
<td>Donor expenses for transplants (IVF and organ)</td>
</tr>
<tr>
<td>Drugs or medicines obtained without a prescription</td>
</tr>
<tr>
<td>Electrolysis</td>
</tr>
</tbody>
</table>

For more information about eligible and ineligible expenses, refer to IRS Publication 502 Medical and Dental Expenses, or contact your tax adviser. You also may call the IRS at 800-829-1040 or visit their website at www.irs.gov/pub/irs-pdf/p502.pdf. No expenses can be reimbursed that are not eligible for reimbursement under IRS rules at the time of reimbursement (as determined by the plan).

**Filing for Reimbursement**

**WageWorks Reimbursement Card**

If you elect to participate in the health care FSA, you are automatically issued a WageWorks reimbursement card to use when paying for eligible expenses. The WageWorks reimbursement card generally will be accepted to the same extent as a debit card at doctors’ offices, medical facilities, hospitals and qualified merchants or merchants certified by the Inventory Information Approval System (IIAS). The WageWorks reimbursement card allows you to pay for eligible health care products directly from your FSA. If the merchant is not qualified by selling at least 90% items that qualify as eligible medical expenses, or by being IIAS-certified, the reimbursement card cannot be used at that location. You will need to pay for the expenses and submit a Pay Me Back Claim Form for reimbursement.

When you activate your reimbursement card online with WageWorks, update your email address in the contact information box since all WageWorks communication to participants is by email. If you would prefer to receive paper statements, you can elect to do so at any time by logging in, selecting the FSA, and then choosing View Account Statement.

The following are some guidelines you should follow to minimize problems with using your reimbursement card:

- **Keep your receipts.** The IRS has rules about how your reimbursement card can be used; WageWorks may ask you to provide copies of your receipts to “substantiate” your purchase. In all cases, be prepared to submit a photocopy of your receipts.

- **Buy from qualified or IIAS-certified merchants.** When using your WageWorks reimbursement card at IIAS-certified merchants, you will not be required to submit receipts to WageWorks. If you purchase items from merchants that are not IIAS-certified, you will be required to provide additional documentation, including a description of the expense, date, amount, and a receipt. A list of the certified merchants can be found at www.sig-is.org (click on SIGIS Merchant List under Publications).
• Use the card only for qualified medical expenses. Whenever you make purchases at an IIAS-certified merchant, the store’s system checking inventory control compares the stock-keeping units (SKU) number for your entire purchase against the SKUs from a list of items that qualify as medical expenses. If you purchase items that qualify as medical expenses at the same time you purchase items that do not qualify as medical expenses, you will be asked for additional payment to purchase the remaining non-medical items.

Online Bill Pay

If you have a health care provider that you visit on a regular basis (e.g., an orthodontist or a chiropractor), you can use the online bill pay option to make payments to the provider as needed or on a regularly scheduled basis.

Traditional Claims Reimbursement

For traditional claims reimbursement, complete a Health Care Pay Me Back Form available at http://benefits.jhu.edu/forms.cfm. Attach supporting proof of your expenses. This proof could be an itemized bill from your health care provider showing:

- Provider name;
- Service date(s);
- Patient name and relationship to account holder;
- Type of service; and
- Patient responsibility.

Provider signature is not required, but can replace need for other proof of service. You can also submit claims via the online Pay Me Back function by logging into your account with WageWorks at www.wageworks.com. You may change your method of reimbursement at any time during the year, regardless of your initial choice, by updating your online profile with WageWorks at www.wageworks.com. If you do not have online access, you can call WageWorks at 877-924-3967 to update your method of reimbursement for you.

Claims Deadline

You have until April 30 of the next year to file claims for reimbursement of expenses incurred through December 31 of the prior year. Your claim must be received by WageWorks no later than April 30. After April 30, you forfeit any money that remains in your account (other than amounts payable for claims you submitted on or before the deadline).

If you terminate employment (or your contributions otherwise end), or if you drop coverage during the year as the result of a qualifying event, you can continue to file claims for reimbursement of eligible expenses incurred prior to your termination of coverage date, up to the full amount of your Health Care FSA election for the current year (less reimbursements already paid to you). However, you will not be reimbursed for claims incurred after your termination of coverage date unless you are eligible for and elect to continue your coverage under COBRA (as described under “COBRA Rights” below).
COBRA Rights

Your health care FSA is subject to the federal law known as COBRA. Under COBRA, if your health care FSA would otherwise terminate because of a COBRA qualifying event and the balance of your health care FSA on the date you experience that qualifying event is more than the amount you would be required to contribute to the account for the remainder of the calendar year, you may elect to continue your participation through the end of the calendar year by making after-tax contributions to your health care FSA. See the "Medical Benefits" section of this Handbook for more details on COBRA rights.

Effect on Taxes

As discussed above, you receive a tax advantage by paying for eligible health care expenses through your health care FSA. However, you cannot claim a deduction for an expense on your tax return if you’ve been reimbursed for the same expense through the health care FSA. Please consult your tax adviser for details.

Dependent Care Flexible Spending Account

How Much You Can Contribute

You generally can contribute up to $5,000 each year to a dependent care FSA (unless you are married and file separate returns, in which case the limit is $2,500). The amount you elect will be deducted in equal contributions from your paycheck during the year. The dollar limit is subject to meeting certain tests required by the IRS to ensure equitable plan participation. As a result, contribution amounts may need to be reduced for certain “highly compensated” employees as defined by the IRS. JHU will notify you if you are affected by this lower limit.

The dependent care FSA can be used to pay expenses to care for a qualified dependent while you work and your spouse works. If you are married (to a spouse) and wish to use a dependent care FSA to pay expenses, your spouse must also work, be a full-time student for at least five months during the calendar year, or be disabled. If either you or your spouse earns less than $5,000, the combined amount you and your spouse contribute may not exceed the lower salary.

- **If you are married and you file a joint income tax return:** You and your spouse together may contribute up to $5,000 to your dependent care FSAs (subject to the income requirement noted above). For example, this means that if your spouse contributes $2,000 to his/her employer’s dependent care FSA, you can contribute up to $3,000 to yours.

- **If you are married and you file separate tax returns:** You and your spouse each may contribute up to $2,500 to your respective dependent care FSAs (subject to the income requirement noted above).

- **If your spouse is a full-time student or is disabled:** The IRS considers your spouse’s earned income to be $250 a month if you have one qualified dependent and $500 a month if you have two or more qualified dependents. You will need to take these amounts into consideration to determine the maximum contribution you can make to your account under the income requirement noted above. Remember to count only the months that your spouse is either in school (must be at least five months during the calendar year) or disabled in calculating your spouse’s earned income and in determining when you have an eligible expense.

If You Receive Employer-Provided Day Care

If you receive employer-provided day care through any other employer (of you or your spouse) for the applicable calendar year, the maximum you can receive from your dependent care FSA is reduced by the value of that employer-provided day care.
Who Is an Eligible Dependent?

The dependent care FSA can be used only to reimburse expenses for the care of eligible dependents. Under applicable law, eligible dependents are:

- Your child (including a stepchild), brother, sister, stepbrother or stepsister (or a descendent of any of those, such as your grandchild or your niece or nephew) who is under the age of 13, who has the same principal residence as you for at least half of the tax year and who does not provide at least half of his/her own support for the current calendar year;
- Your spouse (for purposes of federal law, meaning only an spouse) who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the tax year; and
- Your dependent who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the tax year. For this purpose, “dependent” includes anyone who is your dependent for federal income tax purposes. In addition, for this purpose only, “dependent” also includes anyone who would qualify as your dependent for federal income tax purposes except that he or she:
  - Files a joint income tax return with another person for the current year; or
  - Has income in excess of the IRS personal exemption amount (this amount is $3,800 for 2012 and is subject to adjustment for inflation each year)

Please note: Under federal tax law, the dependent care FSA may not be used for expenses of domestic partners or their children, unless they qualify as your eligible dependent under the above definition.

Eligible Dependent Care Expenses

If you and your spouse both work or if you work and your spouse is a student meeting the requirements discussed above or is disabled, you may be reimbursed from your dependent care FSA for the following expenses for the care of an eligible dependent:

- Services provided by babysitters or caregivers in or outside your home;
- Services provided by a licensed child care center, nursery school, or elder care center;
- Expenses for a housekeeper whose services include care of an eligible dependent; and
- FICA (Social Security and Medicare) taxes and other taxes you pay to or on behalf of a caregiver.

For more information about eligible dependent care expenses, refer to IRS Publication 503 Child and Dependent Care Expenses or contact your tax adviser. You also can call the IRS at 800-829-1040 or visit their website at www.irs.gov/pub/irs-pdf/p503.pdf. (Of course, no expenses can be reimbursed that are not eligible for reimbursement under IRS rules at the time of reimbursement.)

If services are provided by a dependent care center, the center must comply with applicable laws and regulations of a state or local government. A “dependent care center” is any facility that provides care for more than six individuals who do not reside at the center and receives a fee, payment or grant for providing services for any of the individuals.

Dependent Care Expenses Not Eligible for Reimbursement

The following is a partial list of dependent care expenses that, under current IRS rules, are not eligible for reimbursement from your dependent care FSA:

- Child support payments;
- Food, clothing and entertainment;
• Overnight camps;
• Extracurricular activities; and/or
• Administrative fees and books.

Also, no reimbursements will be made for otherwise eligible expenses for services rendered by any person for whom you or your spouse are entitled to a deduction on your federal income tax return for the applicable tax year, or who is your child (including a stepchild or a foster child) who will be under the age of 19 at the end of your tax year.

**Mid-Year Changes to Your Dependent Care Flexible Spending Account**

You may be allowed to change your dependent care FSA election during the year if there is a significant increase or decrease in the cost of your dependent care. However, this special election is not allowed if the dependent care provider is related to you. Other changes may be permitted as described in the “Changes to Your Benefits” Chapter.

**Filing for Reimbursement**

The dependent care FSA is administered by WageWorks. After you enroll, you may access your account online or by phone. Your account statement details your last month’s account activity and may also include items that require your immediate attention. Your account has a Pay My Provider feature (similar to online bill pay), which allows you to schedule monthly payments to your dependent care provider without ever writing a check.

Here’s how to file a claim for reimbursement from your dependent care FSA:

1. Pay your care provider and if possible, obtain a receipt.

2. Complete a Dependent Care Pay Me Back Form, available at [http://benefits.jhu.edu/forms.cfm](http://benefits.jhu.edu/forms.cfm). Be sure to enter the name, address, and Social Security or taxpayer identification number of the person or organization that provided the services. You will also need to indicate on the form that you have not and will not claim the expenses on your federal income tax return. There is also a Pay Me Back online option available when you log into your account at [www.wageworks.com](http://www.wageworks.com).

3. Attach a dated receipt to the form, and send both to the address shown on the form. Your receipt can be a bill, an invoice or a receipt only. Cancelled checks are not sufficient to file a claim for reimbursement.

4. If no receipt is available, have your provider sign your Dependent Care Pay Me Back Form to authenticate your claim.

5. Don’t forget to sign the reimbursement form. Claims will be denied if you do not sign the form.

You can have your dependent care FSA reimbursement checks mailed to you or you can elect direct deposit of these amounts into your checking or savings account. To use the direct deposit feature you will need to complete and sign an application form. Application forms are available online at [http://benefits.jhu.edu/resources/forms.cfm](http://benefits.jhu.edu/resources/forms.cfm). If you do not have online access, forms are available from WageWorks or through the Benefits Service Center.

With the dependent care FSA, you can be reimbursed only up to the amount in your account at the time you file a claim. If your claim exceeds the balance in your account, the outstanding amount of your claim will be carried over and paid automatically as new contributions are added to your account. However, if you terminate participation during the year, you will not be reimbursed for claims incurred after your termination of participation.
Claims Deadline
You have until April 30 of the next year to file claims for reimbursement of eligible expenses incurred through December 31 of the prior year. Your claim must be received by WageWorks no later than April 30. After April 30, you forfeit any money that remains in your account (other than amounts payable for claims you submitted on or before the deadline).

*Please note:* The total amount of your before-tax contributions made during the year are reported to the IRS regardless of how much you are reimbursed through year-end or when reimbursements are made.

Dependent Care FSA vs. Child Care Tax Credit

As described above, you receive a tax advantage for eligible dependent care expenses through your dependent care FSA. Some taxpayers also may claim a federal child care tax credit on their tax returns. However, you cannot claim a tax credit for an expense if you’ve been reimbursed for the same expense through the dependent care FSA.

Example of Key Differences

The following are the key differences between using the dependent care FSA and taking the federal child care tax credit:

<table>
<thead>
<tr>
<th>Using the Dependent Care Flexible Spending Account</th>
<th>Using the Federal Child Care Tax Credit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>The maximum annual contribution is $5,000 ($2,500 if you’re married but file a separate return).</td>
<td>The maximum annual expense applicable toward the tax credit is $3,000 for one child or $6,000 for two or more children. **</td>
</tr>
<tr>
<td>Contributions are excluded from taxable income for federal and state income tax purposes.</td>
<td>A percentage of expenses is applied as a credit against federal income taxes owed (the percentage decreases as your adjusted gross income increases).</td>
</tr>
<tr>
<td>Contributions are free from Social Security taxes, which may slightly reduce your Social Security benefits.</td>
<td>Tax credit doesn’t affect FICA taxes or Social Security Benefits.</td>
</tr>
<tr>
<td>You must decide your contribution amount at the beginning of the year before you incur expenses; you forfeit any unused amount.</td>
<td>You determine the amount of your tax credit at the end of the year, after you incur all expenses; there’s nothing to forfeit.</td>
</tr>
<tr>
<td>Eligible expenses are those incurred during the calendar year and after your eligibility date.</td>
<td>Tax credit applies to eligible expenses incurred during the calendar year.</td>
</tr>
</tbody>
</table>

* If you are married to a spouse, you can generally claim the tax credit only if you file a joint income tax return.

** This reflects federal tax credit amounts for taxable years beginning January 1, 2012. (The federal tax credit does not directly reduce your state income tax in Maryland and most other states, but Maryland and some other states have separate provisions for reducing taxable income based on dependent care expenses.)

Although you cannot use the dependent care FSA and the tax credit for the same expenses, you may apply any eligible expenses not claimed under one method to the other. Please consult your tax adviser for specific details based on your personal situation.
Leaf of Absence

If you are on an unpaid leave of absence, including an approved Family and Medical Leave, participation in a dependent care FSA is ended. Claims may be submitted for charges incurred prior to the coverage end date and will only be paid from the contributions currently in the account. When you return to work in an eligible status, because your eligibility status change is considered a life event, you will be able to enroll in a dependent care FSA. If you return to work during the same calendar year and within 30 days of the date your leave began, your dependent care FSA election will be reinstated with no break in coverage upon your return to work unless you are eligible to change your election for some other reason.

Additional Information About Your Flexible Spending Accounts

Contribution Limits for Highly-Paid Employees

Health care and dependent care FSAs are subject to nondiscrimination tests that apply to these plans under the Internal Revenue Code. JHU will, if necessary, reduce or stop contributions by highly-compensated participants to prevent the FSAs from failing these tests. You will be notified during the Plan Year if there is any necessary adjustment that must be made to your contribution amount to either type of FSA because of the required discrimination testing.

Effect on Other Benefits

Even though you reduce your taxable income by using the FSAs, you are not reducing your pay for determining any JHU pay-related benefits, such as disability, life insurance or retirement plan contributions. Pay, for purposes of determining your benefits, is based on your pay before your FSA contributions are deducted.

Social Security

The FSA contributions you make will reduce the amount of Social Security taxes you pay. If your taxable pay is below the Social Security taxable wage base, your future Social Security retirement benefits may also be reduced.

When Coverage Ends

When your employment with JHU ends, contributions to your dependent care FSA stop on that date. Your contributions to the health care FSA also will stop, unless you are eligible for and elect and pay for COBRA coverage under the health care FSA.

In addition, your FSA contributions will cease on the earliest of the following:

- The date you no longer satisfy the eligibility requirements for that FSA;
- The date you no longer have an effective election to make contributions to that FSA in place; or
- The date JHU terminates the FSA.

Situations Affecting Flexible Spending Account Contributions

If You Are on a Leave of Absence

If you are on a leave of absence without pay that lasts 30 days or less, your FSA elections will be reinstated upon your return to work during the same calendar year. If you are on a leave of absence without pay that lasts longer than 30 days or if you return to work after the start date of the next calendar year, your FSA
If your eligible employment terminates and you return to eligible employment less than 31 days later (and within the same Plan Year), your previous FSA elections will automatically be reinstated upon your return to work.

If you return to eligible employment more than 30 days after you cease to be eligible to participate in the FSAs because of termination or for any other reason, or if you return to an eligible status during the next calendar year, your FSA elections will not be reinstated. However, if your employment is terminated involuntarily due to reduction in force and you are rehired during the calendar year and within 12 months, or if you voluntarily resign in good standing and are rehired during the calendar year within six months (but later than 30 days) following your termination, you may re-enroll in FSA benefits upon your return to work. Your FSAs will reflect any reimbursements already paid to you for the calendar year of your termination.

If you are rehired after a greater period than stated above following your termination, you will be eligible for benefits as a new hire subject to any waiting period that applies to new hires.

For Other Information, Go To…

<table>
<thead>
<tr>
<th>The Big Picture</th>
<th>For general information about JHU’s overall benefits program and how the myChoices Program works</th>
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<tr>
<td>Changes to Your Benefits</td>
<td>For information on how changes in family or work situations may affect your coverage</td>
</tr>
<tr>
<td>Administrative Information</td>
<td>For important facts about FSA plan administration and the rights you may have under ERISA</td>
</tr>
</tbody>
</table>
Chapter 6 – Life, Accidental Death and Dismemberment, and Business Travel Accident Insurance

FAST FACTS

If you are eligible:

- JHU automatically provides you with basic life insurance coverage:
  - If you are faculty or staff, you receive coverage of $10,000; or
  - If you are a bargaining unit employee, you receive coverage equal to 1x your base annual salary, rounded to the next lower $1,000.

- You can elect supplemental life insurance coverage for yourself;

- You can elect dependent life insurance coverage for your eligible dependents:
  - If you are faculty or staff, you can choose from one of two coverage options for your eligible dependents; or
  - If you are a bargaining unit employee, JHU pays for a single coverage option for your eligible dependents.

- If you are faculty or staff, JHU automatically provides you with AD&D of $10,000. AD&D coverage is not available to bargaining unit employees;

- If you are faculty or staff, you can choose additional AD&D insurance coverage of $50,000, 1.5 times your salary, 2.5 times your salary and 4 times your salary for yourself, plus coverage for certain family members. AD&D insurance coverage is not available to bargaining unit employees or their families; and

- JHU automatically provides you with additional insurance coverage if you die while traveling on JHU business:
  - If you are faculty or staff, you have $200,000 in coverage; or
  - If you are a bargaining unit employee, you have $50,000 in coverage.

Life, AD&D, and business travel accident insurance coverage offers financial protection for you and your family by providing benefits in cases of death, accidents, or other covered losses.

Please note: The coverage amounts described in this chapter are maximum benefits that are payable based on a covered loss. For some types of coverage, benefits may vary based on the particular loss experienced. Also, note that this chapter provides only a summary of some of the key features of the benefits described. For full details on benefits, you should always review the appropriate benefits booklet or insurance policy provided by the Insurer for any coverage in which you are enrolled (or that you are considering electing).

- Life Insurance benefits are provided under JHU’s employee benefit plan through the following coverage options:
  - Basic life insurance;
  - Supplemental life insurance; and
– Dependent life insurance.

• AD&D is provided under JHU’s AD&D insurance plan. This coverage is available only to faculty and staff; it is not available for bargaining unit employees.

• Business travel accident insurance is provided under JHU’s group travel insurance plan.

JHU pays the full cost of basic life insurance, $10,000 of AD&D (if applicable) and business travel accident insurance coverage. You pay the cost of any supplemental life insurance, dependent life insurance, and AD&D insurance you elect. Like life insurance, additional AD&D (if applicable) can be purchased for yourself and your eligible dependents.

**Benefits At-A-Glance**

**Basic and Supplemental Life Insurance**

JHU provides you with basic life insurance coverage at no cost:

• If you are faculty or staff, you receive coverage of $10,000;

• If you are a bargaining unit employee, you receive coverage equal to your base annual salary, rounded to the next lower $1,000.

You have the opportunity to elect supplemental life insurance coverage:

• If you are faculty or staff, there are four life insurance options that provide $50,000, or 150%, 250%, or 400% of your base annual salary (to a maximum of $2,000,000 in total coverage); or

• If you are a bargaining unit employee, you may elect supplemental life insurance coverage equal to 1x your base annual salary, rounded to the next lower $1,000 (to a maximum of $2,000,000 in total coverage).

If you elect supplemental life insurance coverage, JHU’s contribution for basic coverage will be applied toward the cost of any supplemental coverage you choose.

*Please note: When your salary or age changes during the calendar year, your life insurance will be adjusted to reflect this change.*

**Dependent Life Insurance**

If you are faculty or staff, you have two coverage options:

• $4,000 for your spouse or domestic partner, and $2,000 per child; or

• $10,000 for your spouse or domestic partner, and $5,000 per child.

If you are a bargaining unit employee, JHU pays for $4,000 in coverage for your spouse or domestic partner, and $2,000 per child.

**Accidental Death & Dismemberment Insurance**

JHU provides faculty and staff with $10,000 of coverage at no cost; and faculty and staff have the opportunity to elect additional coverage for themselves and certain family members of $50,000, 1.5 times your salary, 2.5 times your salary and 4 times your salary, subject to a maximum of $2,000,000.

Bargaining unit employees are not eligible for AD&D insurance coverage.
Business Travel Accident Insurance

JHU provides you with coverage at no cost:
• If you are faculty or staff, you have $200,000 in coverage; or
• If you are a bargaining unit employee, you have $50,000 in coverage.

Eligibility

In general, the eligibility for life, AD&D, and business travel accident insurance coverage is consistent with the eligibility requirements outlined in Chapter 1, “The Big Picture.” However, these insurance coverages have the following additional eligibility requirements:
• Full-time visiting faculty and staff may elect life insurance coverage by paying through after-tax payroll deductions. (See “Basic and Supplemental Life Insurance — Cost of Coverage” in this section for more information on the cost of life insurance coverage, including tax implications.)
• Bargaining unit employees and their dependents are not eligible for AD&D coverage.
• Eligibility for dependent children is as follows:
  – Dependent life insurance: Coverage may begin upon live birth of your dependent child; your dependent child may remain covered until the end of the year in which he or she turns age 26. Coverage for a dependent child may be continued past the age limit if that child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be provided within 31 days after the date the child attains the age limit and at reasonable intervals after such date.
  – AD&D (faculty and staff only): Coverage for your dependent child begins at birth. Your dependent child may remain covered until the end of the year in which he or she turns age 26. Unmarried dependent children covered under the policy who are incapable of self-sustaining employment by reason of mental or physical incapacity, and are primarily dependent on the insured for support and maintenance, may continue to be eligible under the policy beyond the age limit.

Naming a Beneficiary

You need to name a beneficiary— the person(s) who receive benefits at your death for your life insurance, AD&D and business travel accident insurance benefits. Your AD&D beneficiary(ies) and business travel accident insurance beneficiary(ies) will be the same as your life insurance beneficiary(ies). If you want to designate beneficiary(ies), a Beneficiary Designation form can be obtained from the Benefits website at http://benefits.jhu.edu/resources/forms.cfm.

You may change your beneficiary(ies) at any time on the benefits enrollment site. You may name anyone (one or more persons) as your beneficiary. If you name more than one beneficiary for any type of coverage, you must indicate what percentage (whole numbers only, no fractions) of the proceeds you would like them to receive.

The total of all percentages must equal 100%. If a named beneficiary dies before you, his/her share will be payable in equal shares to any other named beneficiaries who survive you.

If there is no designated beneficiary on file at the time of your death, benefits generally will be paid to persons related to you and who survive you, in the following order:
• Your spouse;
• Your children (including legally adopted children);
• Your parents; and
• Your brothers and sisters (including legally adopted siblings)
• Your estate.

If you die, the life insurance benefit your beneficiary receives will be tax-free. The beneficiary may work with the life insurance carrier to select a payment method at the time of the claim.

You are automatically the beneficiary of any dependent life insurance or dependent AD&D insurance coverage you elect.

As Your Family Grows and Changes

In case of marriage, birth, divorce or any other life event, you should review your coverage and your beneficiary designations. Contact the Benefits Service Center to change your life insurance coverage as the result of a qualifying event, or to request new beneficiary designation forms.

When Coverage Begins

Your basic life insurance, AD&D insurance and business travel accident insurance coverage begins on the later of:
• Your first day of employment; or
• The first day you become eligible for coverage.

If you are not actively at work on the date you become eligible for coverage, your coverage will take effect after you return to work for one full day. Your coverage elections generally become effective on the effective date shown on your Benefits Confirmation Statement.

Optional insurance coverage (supplemental life insurance, dependent life insurance, and additional AD&D insurance for you or your dependents) begins on:
• The first day of eligibility (shown on your Benefits Confirmation Statement); or
• On January 1 of the year following your annual enrollment election, provided you elect coverage, are actively at work and follow the enrollment requirements and deadlines. If evidence of insurability is required, insurance coverage will begin on the later of January 1 or the date any evidence of insurability is approved.

If you do not elect supplemental life insurance, JHU-provided basic life insurance will be provided to you on the later of your hire date or your eligibility date.

If you are faculty or staff and do not elect additional AD&D insurance for yourself, JHU-provided AD&D of $10,000 will be provided to you on the later of your hire date or your eligibility date.

When Coverage Ends

Your Coverage

Your life, AD&D, and business travel accident insurance coverage will generally end on the earliest of the following dates:
• The day the applicable plan is terminated;
• Your employment terminates:
  – Basic life, supplemental life and AD&D insurance coverage terminates on the last day of the month in which your employment terminates; and
  – Business travel accident insurance coverage terminates on the date your employment terminates.
• The last day of the month in which you cease to satisfy the eligibility requirements or the applicable coverage;
• If you fail to make any required contributions when due, the last day of the period for which coverage is paid; or
• The day of your death.

Your Dependents’ Coverage

Your eligible dependents’ life and/or AD&D insurance coverage will end on the earliest of the following dates:
• The day the applicable coverage is terminated for all dependents;
• The day your coverage ends;
• The last day of the month in which your employment terminates;
• The last day of the month in which your dependent ceases to be eligible for coverage;
• If you fail to make any required contribution when due, the last day of the period for which coverage is paid;
• The day the dependent becomes covered as an active JHU employee; or
• The day of your death.

Portability Option

If you leave JHU or retire, you may be able to take your life insurance and AD&D insurance with you and continue to pay group term life insurance rates directly to the provider. Rates may be higher than you paid as an active employee.

You cannot continue your coverage if:
• You are age 80 or older,
• You have converted your coverage to an individual policy, or
• Due to sickness or injury, you were not actively at work on the date prior to your termination of employment.

There are maximum coverage levels available for portability. To learn more about your portability options, contact Securian Life at 1-866-365-2374.

Continuing/Converting Coverage

If you leave JHU or if you become ineligible for coverage, you may be able to continue all or a portion of your life, supplemental life and/or dependent life insurance coverage by applying to the life insurance company for an individual policy.

To continue one or more of these coverages, you or your dependent must apply and pay the premium directly to the insurance company within 31 days after your JHU coverage ends. You must also meet any other requirements of the insurance company.

Coverage availability is based on the policies being issued by the insurance company at that time.
Basic and Supplemental Life Insurance

Amount of Coverage

Provided you are eligible, JHU provides basic life insurance coverage at no cost to you. Benefits are generally paid as a single lump sum. However, your beneficiary may be able to request installment payments.

- **If you are faculty or staff**, you receive basic life insurance coverage of $10,000;
- **If you are a bargaining unit employee**, you receive basic life insurance coverage equal to your base annual salary, rounded to the next lower $1,000.

You have the opportunity to elect supplemental life insurance coverage:

- **If you are faculty or staff**, there are four life insurance options that provide $50,000, or 150%, 250%, or 400% of your base annual salary (to a maximum of $2,000,000 in total coverage) rounded to the next higher $1,000;
- **If you are a bargaining unit employee**, you may elect supplemental life insurance coverage equal to your base annual salary (to a maximum of $2,000,000 in total coverage), rounded to the next lower $1,000, subject to the required evidence of insurability.

If you are a full-time visiting faculty member, you are automatically provided with life insurance coverage equal to 150% of your annual base salary, rounded to the next lower $1,000. JHU pays the full cost of this coverage. You may purchase supplemental insurance coverage equal to 100% of your annual base salary, rounded to the next lower $1,000. You will pay the cost of this supplemental coverage, at a rate that varies by your age and benefit amount. You may elect to limit your life insurance coverage to $50,000 but will not be eligible for supplemental insurance coverage. Visiting faculty are not eligible for AD&D.

Cost of Coverage

You and JHU share in the cost of your life insurance coverage as shown in your Benefits Confirmation Statement. Life insurance costs are based on age.

Up to $50,000 of JHU-paid life insurance coverage may be provided as a tax-free benefit. However, the cost of any JHU-provided life insurance coverage greater than $50,000 will be reported on your W-2 form as part of your taxable income (this is called “imputed income”). For example, for $60,000 of life insurance, only the IRS imputed cost for $10,000 insurance ($60,000 minus $50,000) would be considered taxable income.

Evidence of Insurability If you are a newly-hired faculty or staff member, you can elect the highest level of life insurance coverage available to you; however, you must complete evidence of insurability if the coverage is greater than $500,000 (to a maximum total coverage amount of $2,000,000).

If you are a current employee and during annual enrollment you elect:

- To move up only one level of life insurance coverage, you will not have to complete evidence of insurability unless your request is greater than $500,000 in total coverage.
- For faculty and staff to move up more than one level of life insurance coverage, you must complete evidence of insurability.
- For bargaining unit employees to enroll in supplemental coverage, you must complete evidence of insurability.
If you elect, but do not qualify for a life insurance coverage level that requires evidence of insurability, your coverage amount will automatically be reduced to the highest option for which you are eligible that does not require evidence of insurability.

**Dependent Life Insurance**

**Amount of Coverage**

Dependent life insurance coverage is available for your eligible dependents. If you are enrolled in dependent life insurance, each of your eligible children is covered, no matter how many children you have.

- **If you are faculty or staff,** JHU offers two dependent life insurance coverage options for spouses, domestic partners and dependent children:
  - $4,000 of coverage for your spouse or domestic partner, plus $2,000 of coverage per child; or
  - $10,000 of coverage for your spouse or domestic partner, plus $5,000 of coverage per child.
- **If you are a bargaining unit employee,** JHU pays for dependent life insurance coverage of $4,000 for your spouse or domestic partner, plus $2,000 of coverage per child.

An employee’s first eligible newborn child is automatically enrolled in $2,000 of dependent coverage for the first 31 days after birth. To continue coverage on this child, you must elect dependent coverage within 31 days, otherwise the coverage will terminate after that period.

You are automatically the beneficiary for dependent life and AD&D insurance on your dependents.

**Cost of Coverage**

If you elect dependent life insurance coverage for some or all of your eligible dependents, your premiums will be paid with after-tax dollars through payroll deductions.

**About Your Life Insurance and Dependent Life Insurance Coverage**

**Accelerated Benefits for Terminal Illness**

If you or your covered dependent is diagnosed as terminally ill with a life expectancy of 12 months or less, you can request advance payment of your JHU life insurance benefits. You can receive up to 100% of your total coverage amount (basic plus supplemental).

The minimum accelerated benefit you may request is $10,000. The maximum accelerated benefit is $1,000,000.

A terminal condition is one caused by sickness or accident which directly results in a life expectancy of 12 months or less. You must provide medical evidence that demonstrates a terminal condition, including certification by your physician.

The life insurance company may refuse your request for an accelerated benefit if:

- You assigned your life insurance coverage — see “Assignment of Your Benefits,” in this section;
- The amount of your life insurance coverage is less than $10,000; or
- You are required by a government agency to request payment of accelerated benefits in order to apply for, obtain or keep a government benefit or entitlement.
Accelerated benefits will be paid to you in a lump sum. You may be required to pay income taxes on your accelerated benefit payment and should discuss this with the insurance company. You should consult your legal counsel or tax advisor before you request an accelerated benefit.

**Suicide Provision**

Supplemental life insurance benefits (or a requested increase in your supplemental life insurance coverage) will not be paid if the deceased commits suicide while sane or insane, within two years of the coverage effective or increase date. Instead, the beneficiary will be paid an amount equal to all your contributions paid for supplemental life insurance coverage, without interest.

**Accidental Death and Dismemberment**

**How These Benefits Work**

Please note: AD&D insurance coverage is available only to faculty and staff. Bargaining unit employees and visiting faculty are not eligible for coverage.

AD&D insurance protects you and/or your insured dependents, 24-hours a day, 365 days a year against covered accidents. Worldwide coverage includes (but is not restricted to) accidents on or off the job, occurring in the home, traveling by train, airplane (with certain exclusions), automobile or other public conveyance. AD&D insurance also includes other benefits, such as special education benefits, travel assistance and medical evacuation benefits.

Benefits are payable in addition to any other insurance coverage that may be in effect at the time of the accident. Please refer to the AD&D insurance policy for more detailed information. (This insurance does not replace business travel accident insurance, which is a JHU-paid benefit.)

JHU provides you with $10,000 of coverage at no cost. You may elect additional coverage amounts of $50,000, 1.5 times your salary, 2.5 times your salary, or 4 times your salary for yourself and for your eligible dependents.

**Amount and Cost of Coverage**

JHU automatically provides you with $10,000 of AD&D insurance coverage at no cost. You have the opportunity to elect additional coverage of $50,000, 1.5 times your salary, 2.5 times your salary, or 4 times your salary for yourself and for your eligible dependents.

You pay the cost of any AD&D insurance you elect through before-tax payroll deductions. If you elect AD&D insurance coverage for a domestic partner and/or their children, deductions are made on an after-tax basis, unless you certify that they are your dependents for tax purposes.

If you choose family coverage, in the event of a loss the coverage amount paid for you, your spouse or domestic partner, and for each eligible child, is based on the composition of your family at that time. This is expressed as a percentage of the elected amount, as shown in the following table:
Family Composition | Your Coverage | Spouse’s or Domestic Partner’s Coverage | Coverage per Child
--- | --- | --- | ---
You, your spouse or domestic partner and children. | 100% of your elected amount. | 60% of your elected amount. | 20% of your elected amount.*
You and your spouse or domestic partner only. | 100% of your elected amount. | 60% of your elected amount. | N/A
You and your children only. | 100% of your elected amount. | N/A | 20% of your elected amount.

*The maximum benefit per spouse/domestic partner is $250,000. The maximum benefit per child is $50,000.

**How AD&D Benefits Are Paid**

Benefits are paid for covered losses that occur within 365 days of, and as a direct result of, an accident or injury. The benefit amount depends on the coverage amount you choose and the extent of the loss.

An “accident” means a sudden, unexpected, unusual, specific and abrupt event that occurs by chance, at an identifiable time and place, during the time you are covered. It does not include any heart, coronary or circulatory malfunction.

If you have an accident that results in:

- **Death**: Your AD&D insurance pays 100% of the coverage amount you elected to your beneficiary. In the event of the death of a covered dependent, you receive benefits based on the percentages shown in the table above, describing family coverage.

- **Injury**: The benefit amount you receive depends on the extent of the loss, as shown in the following chart.
<table>
<thead>
<tr>
<th>If an accident causes the loss of...</th>
<th>You receive this % of your covered amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Both hands or both feet</strong></td>
<td></td>
</tr>
<tr>
<td>(the hands or feet are completely severed through or above the wrist or ankle joint)</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Entire sight of both eyes</strong></td>
<td>100%</td>
</tr>
<tr>
<td>(complete loss of vision that cannot be regained)</td>
<td></td>
</tr>
<tr>
<td><strong>One hand and the entire sight of one eye</strong></td>
<td>100%</td>
</tr>
<tr>
<td>(the hand is severed through or above the wrist, and one eye suffers complete loss of vision that cannot be regained)</td>
<td></td>
</tr>
<tr>
<td><strong>One foot and the entire sight of one eye</strong></td>
<td>100%</td>
</tr>
<tr>
<td>(the foot is severed through or above the ankle joint, and one eye suffers complete loss of vision that cannot be regained)</td>
<td></td>
</tr>
<tr>
<td><strong>Loss of speech and hearing of both ears</strong></td>
<td>100%</td>
</tr>
<tr>
<td>(loss of speech which does not allow audible communication to any degree, and loss of hearing, neither of which can be regained)</td>
<td></td>
</tr>
<tr>
<td><strong>Quadriplegia</strong></td>
<td>100%</td>
</tr>
<tr>
<td>(complete and irreversible paralysis of both upper and lower limbs)</td>
<td></td>
</tr>
<tr>
<td><strong>Paraplegia</strong></td>
<td>75%</td>
</tr>
<tr>
<td>(complete and irreversible paralysis of both lower limbs)</td>
<td></td>
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<tr>
<td><strong>Hemiplegia</strong></td>
<td>50%</td>
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<td>(complete and irreversible paralysis of upper and lower limbs on one side of the body)</td>
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<td><strong>One hand or one foot</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Entire sight of one eye</strong></td>
<td>50%</td>
</tr>
<tr>
<td>(complete loss of vision that cannot be regained)</td>
<td></td>
</tr>
<tr>
<td><strong>Speech</strong></td>
<td>50%</td>
</tr>
<tr>
<td>(that cannot be regained)</td>
<td></td>
</tr>
<tr>
<td><strong>Hearing in both ears</strong></td>
<td>50%</td>
</tr>
<tr>
<td>(complete loss of hearing in both ears)</td>
<td></td>
</tr>
<tr>
<td><strong>Thumb and index finger of same hand</strong></td>
<td>25%</td>
</tr>
<tr>
<td>(the fingers are completely severed through or above the joint closest to the hand)</td>
<td></td>
</tr>
</tbody>
</table>

If more than one covered loss is sustained by you or an eligible dependent as the result of any single accident, payment will be based on the loss that pays the greatest amount to you or your beneficiary.
Benefits for Work-Related Injuries

AD&D insurance benefits are paid for accidental injuries, including those that are work-related. If you have a work-related injury, you may also be eligible for Workers’ Compensation benefits.

Additional AD&D Insurance Benefits

Your personal accident insurance coverage includes the following additional benefits:

- **Spouse Education Benefit:** If you elect family coverage and suffer loss of life as a result of a covered accident and are survived by a spouse or domestic partner, provided that your spouse enrolls in a program of higher education within 12 months after your death. The benefit payable will be the least of:
  - the actual tuition charged for all such education,
  - 20% of your amount of AD&D insurance or
  - $5,000.

Only expenses occurring within 30 months after the date of your death will be eligible for reimbursement.

- **Dependent Child Education Benefit:** If you elect family coverage and suffer loss of life in a covered accident, education benefits will be paid for your dependent children in an amount equal to the lesser of the following:
  - The actual annual tuition, exclusive of room and board, charged by an educational institution per school year; or
  - $3,750 to or on behalf of any dependent child who, on the date of the accident, was enrolled as a full-time student in any institution of higher learning beyond the 12th grade level, or was at the 12th grade level and subsequently enrolls as a full-time student in an institution of higher learning within 365 days following the date of the accident. This benefit is payable annually for a maximum of four consecutive yearly payments, but only if the dependent child continues his/her education as a full-time student in an institution of higher learning.

- **Common Disaster Benefit:** If you elected family coverage, and both you and your spouse/domestic partner lose your lives in the same covered accident (or within 90 days of that accident), the benefit payable on behalf of your spouse/domestic partner’s death will automatically increase to the same benefit amount payable as the result of your death.

- **Coma Benefit:** If you or a covered dependent are rendered comatose within 30 days following the date of an accident that caused the injury, and if the coma continues for a period of 30 or more consecutive days, benefits will be payable to the insured in a monthly benefit equal to 1% of the coverage amount. The benefit is payable monthly for as long as the insured person remains comatose due to that injury, but ceases on the earliest of:
  - The date the insured person ceases to be comatose due to that injury;
  - The date the insured person dies; or
  - The date the total amount of monthly coma benefits paid for all injuries caused by the same accident equals 100% of the covered amount.

- **Disappearance Benefit:** If you or a covered dependent have not been found after one year from the date of a disappearance or similar travel accident, the death will be considered a covered loss and the beneficiary will be eligible for a benefit.

- **Exposure Benefit:** If you or a covered dependent suffer a loss due to exposure to the elements, it will be covered as if it were due to injury, provided such loss is unavoidable due to an accident.
What’s Not Covered

AD&D insurance does not cover any loss caused by or resulting from:

- Self-inflicted injury, or self-destruction whether sane or insane;
- Suicide or attempted suicide, whether sane or insane;
- Your commission of, or attempt to commit, a felony, or to which a contributing cause was your being engaged in an illegal occupation;
- Bodily or mental infirmity, illness or disease;
- A loss to which a contributing cause was [your] being intoxicated or under the influence of any narcotic;
- Infection, other than infection occurring simultaneously with, and as a direct and independent result of, the accidental injury;
- Medical or surgical treatment or diagnostic procedures or any resulting complications, including complications from medical misadventure;
- Travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
- War or any act of war, whether declared or undeclared.

Business Travel Accident Insurance

How It Works

Business travel accident insurance provides protection in case of accidental death, paralysis, or loss of sight, hearing, speech, a limb, or thumb and index finger of the same hand while on a business trip authorized by JHU. This includes events occurring while you attend a business meeting, conference, or seminar, whether locally or out of town.

Coverage begins from the time you leave home or a JHU work site (whichever is later) for a business trip. It ends when you return to home or a JHU work site (whichever is first).

Business travel accident insurance does not cover:

- Commuting to and from the normal place of work;
- Vacation travel; or
- Time taken for vacation purposes during a business trip.

Coverage applies to you only. It does not apply to a spouse or domestic partner, or to dependent children who may accompany you on a business trip.

Amount and Cost of Coverage

JHU provides you with coverage at no cost. Coverage is limited under certain circumstances (e.g., if the loss is associated with scuba diving); please see the actual policy for details.

- If you are faculty or staff, you have $200,000 in coverage; or
- If you are a bargaining unit employee, you have $50,000 in coverage.

Benefit Limitations

Business travel accident insurance coverage pays a maximum of $2,000,000 on behalf of all covered individuals injured in a single accident. If the total claims from a single accident exceed $2,000,000, covered
individuals and/or their beneficiaries will receive a proportionate share of this maximum amount, based on the total amount of insurance that would have been payable if there was no benefit limitation.

What’s Covered

Benefits are paid for covered losses that occur within 365 days of, and as a direct result of, an accident or injury. An “accident” means a sudden, unexpected, unusual, specific and abrupt event that occurs by chance at an identifiable time and place. It does not include any heart, coronary, or circulatory malfunction.

Benefits will be paid for the stated percentage of your covered amount, as shown in the table below.

<table>
<thead>
<tr>
<th>If an Accident Causes the Loss of...</th>
<th>The Plan Pays... (% of coverage amount)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
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<tr>
<td>Both hands or both feet</td>
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<td></td>
</tr>
<tr>
<td>Hearing in both ears</td>
<td>50%</td>
</tr>
<tr>
<td>(complete loss of hearing in both ears that is irrecoverable)</td>
<td>50%</td>
</tr>
<tr>
<td>Thumb and index finger of same hand</td>
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</table>

The maximum benefit payable will not exceed your coverage amount ($200,000 if you are faculty or staff, or $50,000 if you are a bargaining unit employee).

Proof of paralysis may be required on a periodic basis.
What’s Not Covered

Business travel accident insurance coverage does not pay benefits for losses resulting from:

- Suicide or attempted suicide while sane, or self-destruction or attempted self-destruction while insane;
- Piloting or serving as a crew member for any vehicle or device for aerial navigation;
- Riding in any aircraft that is owned, operated, or leased by or on behalf of JHU unless a specific written agreement has been obtained to provide such coverage;
- Sickness or disease (except pyogenic infections which occur as the result of an accidental cut or wound);
- Service in the armed forces of any country;
- Injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, (including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens) unless the drug is taken as prescribed or administered by a licensed physician;
- Injury sustained while committing or attempting to commit a felony; or
- Injury sustained while operating a motor vehicle while legally intoxicated from the use of alcohol.

Combining Business with Personal Time Off

You may want to combine some personal time off or paid time off with business travel. Business travel accident insurance coverage does not apply during this personal time off. However, any personal accident insurance coverage you or your dependents have will apply.

Situations Affecting Your Life and AD&D Insurance

If You Retire

Your life and AD&D insurance coverage ends when you retire, unless you elect to continue the available coverage as described in the applicable insurance policies.

If You Are on a Leave of Absence

If you are on an approved, unpaid leave of absence, including a leave without pay under JHU’s Family and Medical Leave Policy, you may continue your supplemental life and dependent life insurance coverage. The Office of Benefits Services will notify you of your required benefit contributions during your leave of absence. Failure to make payment for the benefit plans you choose to continue while on leave of absence will result in the loss or cancellation of coverage.

If you decide not to keep your optional coverage during your leave of absence, JHU will continue your basic life insurance coverage while you’re on leave. When you return to JHU, you will be re-enrolled in the optional benefits that were in place prior to your leave, or you may be permitted to change your benefit elections within 30 days of your return, subject to any required evidence of insurability (in accordance with the rules for changing elections under the myChoices Program).

AD&D insurance coverage does not continue while on an unpaid leave of absence but is reinstated upon return.

If you are on a paid leave of absence, you will keep your business travel accident insurance coverage if you are receiving 50% or more of your regular pay.
If a Dependent Child is Disabled

If your dependent child’s AD&D insurance coverage would otherwise terminate due to age, coverage can be continued if your dependent child is incapable of self-sustaining employment as a result of mental or physical incapacity. In this case, the incapacity must have begun before the child reached the end of his/her eligibility period, and proof of the incapacity must be provided to the insurance company within 31 days of the date coverage would normally have ended.

Assignment of Your Benefits

For purposes of estate tax planning, you may want to assign ownership of your basic life and/or supplemental life insurance benefits to another person or organization through irrevocable assignment. To obtain forms necessary to assign your Life Insurance coverage, contact the Benefits Service Center.

When you assign ownership, keep in mind that you give up the right to change or cancel your coverage. In addition, you cannot change your beneficiary or cancel your assignment yourself. If you assign ownership of your life insurance, you also give up the right to request advance payment of benefits if you become terminally ill.

You may wish to seek legal counsel before you make a decision to assign some or all of your benefits.

For Other Information, Go To…

| The Big Picture | For general information about JHU’s benefits program and how the myChoices Program works |
| Changes to Your Benefits | For information on how changes in family or work situations may affect your coverage |
| Administrative Information | For important facts about life, AD&D, and business travel accident insurance plan administration, and your rights under ERISA |
| Resources | For a list of contacts and available resources |
Chapter 7 – Leaves & Disability

FAST FACTS

- If you give birth and meet the eligibility requirements, you are entitled to six weeks of fully-paid leave following the birth of a child.
- If you become a birth mother, father, same-sex spouse/partner, adoptive parent or parent via surrogate, you are entitled to four weeks of fully paid parental leave to be taken in consecutive blocks of time or intermittently within the first 12 months after the birth of a child or placement of an adopted child.
- If you are enrolled in coverage, short-term disability (STD) benefits generally continue 60% of your pre-disability pay for up to 11 weeks if you become disabled and are unable to work;
- If you have been disabled for 90 consecutive days, long-term disability (LTD) benefits generally continue 60% of your pre-disability pay, provided your disability continues. You do not need to enroll in LTD coverage — JHU provides this plan at no cost to you;
- LTD benefits are payable up to age 65, provided you remain disabled; extended payment periods apply if you become disabled on or after age 60;
- If you are able to work in some manner while you are disabled, work incentive benefits continue a portion of your LTD and STD benefit while you are employed; and
- If you die after receiving LTD benefits for at least 180 consecutive days, your beneficiary will receive a survivor income benefit.

JHU offers leave benefits and disability plans that continue a portion of your pay if you become a new parent or are unable to work due to an illness or injury. Birth Recovery Leave and Parental Leave is provided by JHU at no cost to you. Short-term disability (STD) coverage is a voluntary benefit — you must enroll in coverage and make the required contributions. Long-term disability (LTD) coverage is automatically provided by JHU at no cost to you.

Benefits At-A-Glance

Birth Recovery Leave
JHU provides you with time off to recover from labor and delivery. Once you meet the eligibility requirements,
- You are entitled to six weeks of fully-paid leave following the birth of a child.
- This benefit must be taken immediately upon the birth of a child.

Parental Leave
JHU provides you with time off to bond and care for a newborn or newly adopted child or child born via surrogate. Once you meet the eligibility requirements,
- You are entitled to four weeks of fully-paid leave.
- This benefit can be taken consecutively or intermittently in full day increments within the first 12 months following the birth of a child or placement of an adopted child, based on a schedule arranged with your supervisor.
Eligibility

In general, the eligibility for family leave (which includes Birth Recovery Leave and Parental Leave) for new parents is consistent with the eligibility requirements outlined in Chapter 1, “The Big Picture.” However, these benefits have the following additional eligibility requirement: Full-time and part-time faculty, visiting faculty, staff and bargaining unit employees who have been employed in an eligible status with continuous service for at least one year are eligible for family leave.

How Birth Recovery Leave Works: This leave may be extended based on medical necessity but not to exceed thirteen weeks. At that point, if eligible, you would be reviewed for long term disability benefits.

Birth Recovery Leave runs concurrently with family medical leave’s 12 week protected leave entitlement.

In advance of the birth, contact The Hartford Insurance Company, the plan administrator for the university to request Birth Recovery Leave: 1-800-303-9744. Have your physician complete the certification form and return it to Central Human Resources. For more information, you can contact them at 443-997-2157 or Birth-ParentalLeave@jhu.edu. When the baby is born, contact The Hartford again to confirm the birth.

How Parental Leave Works

This leave covers birth mothers, fathers, same-sex spouses/partners, adoptive parents of children under age 12 and parents of children born via surrogate.

If you are an eligible mother, Parental Leave will begin after Birth Recovery Leave has been exhausted.

Parental Leave will run concurrently with the 12 weeks of job protection under FML, if still available.

To request parental leave, complete the Family Leave for New Parents Request Form available online at https://benefits.jhu.edu/secure/dotnet/flnp_client/requestform.aspx. Discuss with your supervisor and agree to a plan for taking continuous or intermittent leave.

Disability

Benefits At-A-Glance

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Short-Term Disability</th>
<th>Long-Term Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>When benefits begin</td>
<td>After 14 consecutive days (your “elimination period”), during which you have been unable to work due to an illness or injury, as defined in “How STD Benefits Work.”</td>
<td>After 90 consecutive days (your “elimination period”), during which you have been unable to work due to an illness or injury and are considered disabled, as defined in “How LTD Benefits Work.”</td>
</tr>
<tr>
<td>Amount you are paid</td>
<td>60% of your pre-disability weekly earnings, to a maximum weekly benefit of $2,500.</td>
<td>60% of your pre-disability monthly earnings, to a maximum monthly benefit payment of $10,000.</td>
</tr>
<tr>
<td>Your cost for this benefit</td>
<td>You pay the full cost for this benefit.</td>
<td>JHU provides this benefit at no cost to you.</td>
</tr>
</tbody>
</table>
Eligibility

The eligibility requirements for STD and LTD coverage are described in “The Big Picture,” the first chapter of this document.

When Coverage Begins

Your coverage for STD and LTD benefits begins as follows:

- **STD**: Your coverage may begin as early as your first day of active, full-time employment with JHU, provided you have enrolled in coverage; and

- **LTD**: Your coverage begins the first day of the month coincident with or next following your completion of 12 months of full-time continuous employment with JHU. However, if you are hired by JHU as an eligible employee within three months after being covered under the long-term disability plan of a previous employer, and you were covered under that plan for at least one year, the 12-month waiting period will be waived. You must provide proof of your prior coverage in order to waive the 12-month waiting period.

Cost

STD coverage is a voluntary benefit. If you elect STD coverage, you pay the full cost of coverage through before-tax payroll deductions.

LTD coverage is provided at no cost to you.

Any STD or LTD payments you receive are considered taxable income in the year in which you receive them.

Short-Term Disability

Short-term disability benefits continue a portion of your pay for a maximum of 11 weeks when an illness or injury prevents you from working.

Electing Short-Term Disability Coverage

Enrollment

If you are a current employee, you may enroll in STD coverage during the fall annual enrollment period, for coverage beginning on January 1 of the following year.

If you are a new employee, you may enroll within 30 days of becoming eligible for coverage. In general, you are eligible the first day of active, full-time employment. However, if an illness or injury (including maternity leave) otherwise prevents you from being actively at work on that date, your coverage becomes effective on the day after you return to active work for a continuous period equal to the time you were not actively working. This return to active work requirement will not exceed 30 days.

How STD Benefits Work

STD benefits begin if an illness or injury prevents you from working for more than 14 consecutive days. Starting on the 15th day of your absence, benefits are payable for a maximum of 11 weeks, but only while you remain disabled.

For the purposes of STD coverage, you are “disabled” if:
• You are unable to perform the material and substantial duties of your regular occupation; and
• You are not being paid to work in any occupation for which you are qualified by education, training or experience.

You are not considered disabled if you are able to earn 80% of your pre-disability income.

To be approved for STD benefits, you must provide medical documentation from your physician or health care provider showing that you are disabled once you have been absent for 14 consecutive days.

While you are disabled, after the 14-day elimination period, STD benefits provide you with 60% of your pre-disability weekly pay, excluding commissions, bonuses and overtime, with a maximum weekly STD benefit of $2,500. Your STD benefits will be reduced by any payments you receive under workers’ compensation, an occupational disease act or law, or under a statutory disability benefit.

A claim overpayment can occur when you receive a retroactive STD payment, when the insurance provider inadvertently makes an error in the calculation of a claim, or if fraud occurs. Claim overpayments are amounts paid to you in excess of what should have been paid under the plan. In an overpayment situation, you will be required to make a full repayment for any claim overpayments.

Recurring Disabilities

If your disability ends but recurs due to the same or a related cause less than 15 days later, it will be considered a resumption of the prior disability. In that case, benefit payments will not be subject to a new elimination period and a single 11-week payment period will apply to both periods of disability combined.

If your disability recurs more than 14 days after the end of a prior disability, it is treated as a new disability and subject to a separate elimination period, as well as a new 11-week maximum payment period.

STD Work Incentive Benefit

If you are disabled but can work in some capacity, you may be approved for work incentive benefits. This allows you to receive a portion of your STD benefits while you work, provided you earn less than 80% of your pre-disability earnings. Work incentive benefits are equal to your regular STD benefit, minus any amount that when combined with your work earnings would exceed 100% of your pre-disability weekly earnings.

Coordination with Family and Medical Leave (FML)

If you are approved for leave under the Family and Medical Leave Act, your STD coverage will continue for up to 12 weeks following the date the leave begins, provided you continue to pay the required premium. If you do not return to work as scheduled in your agreement with JHU, your STD coverage will be terminated.

Continuation of Other Benefits

While you are receiving STD benefits, coverage for certain JHU benefits will continue as long as you continue to pay your share of the cost for those benefits. If you do not make your payment by its due date, your benefits will be cancelled. Contact the Benefits Service Center for more information.

Long-Term Disability

If you are disabled and unable to work due to an illness or injury, long-term disability (LTD) benefits generally pay 60% of your pre-disability monthly earnings to a monthly maximum benefit of $10,000. You are not considered disabled if you are able to earn 80% of your pre-disability income.
For the purposes of LTD coverage, “disabled” means:

- **For faculty and senior staff**, you are “disabled” if you are continuously unable to perform the material and substantial duties of your regular occupation and not gainfully employed;

- **For support staff and bargaining unit employees**, you are:
  - First 24 months: Unable to perform the material duties of your regular occupation; or
  - After 24 months: Unable to engage in any occupation for which you are or become qualified by education, training or experience.

**How LTD Benefits Work**

LTD benefits begin if you are disabled and unable to work after 90 consecutive days. After the 90-day elimination period, LTD benefits are paid at 60% of your pre-disability monthly earnings (to a monthly maximum of $10,000) until the earlier of:

- The date you are no longer disabled; or
- The date you reach age 65 (extended payment periods may apply if you become disabled on or after age 60).

Your pre-disability monthly earnings are your regular monthly earnings, excluding commissions, bonuses or overtime. The LTD benefits you receive will be reduced by any payments you receive from:

- Social Security;
- Workers compensation;
- Any payments under an occupational disease act or law;
- Any occupational accident coverage;
- A state teachers retirement system;
- Benefits under a statutory disability benefit law;
- The Railroad Retirement Act;
- The Canada Pension Plan, Québec Pension Plan, or Canada Old Age Security Act; or
- Any other public employee retirement system plan.

If benefits under one of the above programs increase while you are receiving LTD benefits, your LTD benefit will not be further reduced based on that increase.

If you expect to become eligible for Social Security disability benefits, it is assumed that you will apply. Service representatives from the LTD insurance company are available to assist you in applying for and securing a Social Security disability award, at no charge to you.

The maximum payment period of LTD benefits depends on your age when you became disabled, as shown in the following table. Benefits will end earlier if you cease to be totally disabled or you fail to comply with any requirements to provide proof of your ongoing disability.

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<tr>
<th>Age When Your Disability Began...</th>
<th>Maximum Payment Period</th>
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<tr>
<td>Age 60 or younger</td>
<td>Until your 65th birthday.</td>
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<tr>
<td>Age 60 through 68</td>
<td>60 months or until your 70th birthday, whichever occurs first.</td>
</tr>
<tr>
<td>Age 69 or older</td>
<td>24 months.</td>
</tr>
</tbody>
</table>
Recurring Disabilities

If your disability ends but recurs due to the same or a related cause less than six months later, it will be considered a resumption of the prior disability. In this case, LTD payments will immediately resume at the initial payment amount with no adjustment for any pay increase you may have received.

If your disability ends and LTD payments stop, but the disability recurs due to the same or related causes six months (or later) after the end of your prior disability, the disability is treated as a new disability and is subject to:

- A new 90-day elimination period;
- A new maximum payment period; and
- Any other plan provisions in effect on the date your disability recurs.

LTD Work Incentive Benefit

If you are disabled but can work in some capacity, you may not be eligible for the full LTD benefit that you would receive if you were unable to work at all but you may be approved for work incentive benefits. Work incentive benefits are equal to a portion of the benefit you would receive if you qualified for full LTD benefits while you work, provided you earn less than 80% of your pre-disability earnings.

- During the first 12 months of employment, a work incentive benefit is calculated as follows:
  - Your full LTD monthly benefit and earnings from work (your “disability earnings”) are added together and compared to pre-disability monthly earnings;
  - If the total exceeds 100% of your pre-disability monthly earnings, your work incentive benefit equals your full LTD monthly benefit reduced by the amount above 100%; and
  - If the total does not exceed 100% of your pre-disability monthly earnings, your work incentive benefit will equal your full LTD monthly benefit amount.

- After the first 12 months of employment, a work incentive benefit will equal your full LTD monthly benefit multiplied by the Adjusted Loss of Salary ratio. Your Adjusted Loss of Salary Ratio is determined by taking:
  - Your pre-disability monthly earnings increased each year on the anniversary of your disability start date by the lesser of (1) an annual rate of inflation based on the US Bureau of Labor Statistics “CPI-W” rate, or (2) 10%;
  - Then subtracting your disability earnings, and dividing the resulting amount by your pre-disability monthly earnings, as increased each year on the anniversary of your disability start date by the lesser of (1) the CPI-W, or (2) 10%.

Coordination with Family and Medical Leave (FMLA)

If you are approved for leave under the Family and Medical Leave Act, your LTD coverage will continue up to 12 weeks following the date of leave. If you do not return to work as scheduled in your agreement with JHU, your LTD coverage will be terminated.

Coordination with Medicare

If you are on disability, and you are receiving Social Security disability benefits, you generally will become eligible for Medicare after 24 months. At this time, Medicare will become your primary medical coverage until you return to active employment. Once you become eligible for Medicare, if you are not an active employee of JHU but you are still covered under JHU’s plan, benefits under JHU’s plan will be treated as secondary to Medicare. This is true even if you do not actually enroll in Medicare, so you should enroll in both Medicare
Part A and Medicare Part B as soon as you become eligible. You should also know that you may pay a penalty if you do not sign up for Medicare when you first become eligible. If you have questions concerning Medicare, you should contact the Social Security Administration.

Additional Benefits and Services

Retirement Plan Contribution

In addition to the long-term disability benefit you receive, the plan will fund an additional 10% benefit, to a maximum of $2,041.67 per month, to the university’s 403(b) Retirement Plan in a TIAA account for as long as you are receiving a monthly disability benefit from the university’s group long-term disability plan. The retirement contribution is a special feature of the long-term disability plan and does not reduce your monthly disability income.

Survivor Income Benefit

If you die while you are eligible for LTD benefits, and you were receiving LTD benefits for at least the previous 180 consecutive days, your beneficiary (as designated under your life insurance plan) will receive a survivor income benefit. This survivor income benefit continues your LTD payments to your beneficiary for a period of six months. If you have no beneficiary, this survivor benefit will be paid as provided in the insurance contract.

Catastrophic Disability Benefit

In case of a catastrophic disability, you will be paid an additional monthly benefit for 12 months. You become eligible for this benefit after you have been disabled for 180 consecutive days.

You will be considered catastrophically disabled, if due to the disability:

- You are unable to perform at least two of six daily living activities, without assistance or regular supervision (a daily living activity includes eating, toilet functions, transferring from a bed, chair or wheelchair; bathing, dressing and/or continence); or
- You have a deterioration in intellectual capacity that poses a health or safety hazard to you or to others, and that requires supervision; and
- You are not gainfully employed.

Catastrophic disability benefits increase your monthly LTD benefit by 10% of pre-disability earnings, to a maximum additional monthly benefit of $5,000. This additional benefit is not subject to increase or reduction due to other sources of income you may be entitled to receive.

Caregiver Respite/Caregiver Training Benefits

While you are receiving catastrophic disability benefits, you are also eligible for certain caregiver benefits. The plan covers the following caregiver respite benefits:

- **Informal home care** is medically necessary care provided at your home or in a private residence by an informal caregiver, in lieu of confinement in a nursing home or care by a paid provider. Care that has been provided for at least six continuous months from the date of your disability will be covered;
- **Companion care** is medically necessary custodial care for a minimum of eight hours a day by an accredited home health care provider while the informal caregiver is on a respite interval. Care must be received by you in your home or in a private residence during a respite interval (a period of one or more consecutive days in which the informal caregiver is temporarily relieved of duties). The plan provides a
maximum of 14 days of companion care per calendar year. Any unused days expire after December 31 each year and cannot be carried over to the following year.

The benefit is equal to the daily companion care cost incurred, which is not to exceed $100 per day.

Caregiver training benefits provide reimbursement of up to $500 for training costs associated with an informal caregiver receiving home care training. Training must be provided by a home health care provider accredited by either the Joint Commission or the Community Health Accreditation Program, the nursing home or the hospital. If you are in a nursing home or hospital, this benefit will be provided only if the training allows you to return to your residence to be cared for by the informal caregiver.

You must submit proof of your incurred costs in order for caregiver respite or training to be reimbursed under the plan.

**Emergency Alert System Benefit**

While you are receiving a catastrophic disability benefit, the plan will reimburse you up to $25 per month for the cost to rent or lease an emergency alert system. An emergency alert system is a communication system in your residence which summons medical attention in case of emergency. Your condition must be such that you could not be left alone without the presence of the emergency alert system.

The emergency alert system benefit is payable to you, in arrears, after every six months following submission of proof for the costs incurred for the system. Any charges incurred for installation, servicing or maintaining the system are not covered. This includes (but is not limited to) charges for normal telephone service while the system is installed, or for a home security system.

**Worksite Modification Benefit**

Worksite modifications are those modifications designed to help you remain at work or return to work. The LTD insurance company will evaluate your eligibility to receive worksite modification benefits or vocational rehabilitation services. You, JHU and the LTD insurance company must agree, in writing, to these services.

If agreed to, worksite modification will be provided for an amount that is up to the greater of:

- $1,500; or
- Two months of your LTD benefits.

**Vocational Rehabilitation Services**

Vocational rehabilitation services are available to assist you in returning to employment. Services might include one or more of the following:

- Job modification;
- Job retraining;
- Job placement; and/or
- Other activities.

Eligibility for vocational rehabilitation services is based on your education, training, work experience and physical and mental capacity. To be considered for vocational rehabilitation services:

- Your disability must be preventing you from working;
- You must have the physical and mental capacities necessary for successful completion of a rehabilitation program; and
- There must be a reasonable expectation that rehabilitation services will help you return to work.
Conversion Option

If you terminate employment with JHU, your disability coverage will end. You may, however, be eligible to purchase LTD insurance under the group conversion policy available through the LTD insurance company.

To be eligible to convert your LTD insurance, you must have been covered by the plan for at least 12 consecutive months on the date your coverage ends. You must apply for coverage with the LTD insurance company, pay the first premium within 30 days after your employment terminates, and meet any other requirements.

You are not eligible to convert coverage if you:
• Are or become insured under another group LTD plan within 30 days after your termination of employment;
• Are disabled under the terms of the policy;
• Recover from a disability and do not return to work for JHU;
• Are on leave of absence; or
• Have coverage under the policy that ends for any of the following reasons:
  – The policy is canceled;
  – The policy is changed to exclude the class of employees to which you belong;
  – You end your working career or retire and receive payment from the JHU retirement plan; or
  – You fail to pay the required premium under the policy.

Features That Apply to Both STD and LTD Plans

Limitations and Exclusions

STD and LTD coverage does not cover any loss caused by, contributed to or resulting from:
• Attempted suicide, while sane or insane, or an intentionally self-inflicted injury or sickness;
• Occupational injury or sickness (STD only); or
• Commission of or attempt to commit a felony.

Benefits are not payable during any period in which you are confined in a penal or correctional institution, provided the period of confinement exceeds 30 days.

When Your Disability Coverage Ends

Your disability coverage will end on the earliest of:
• The date the plan is terminated;
• For STD coverage, if you fail to pay the required premium, the last day for which you have paid for coverage; or
• The date you retire or otherwise terminate employment with JHU.

If you cease work due to leave of absence or military leave, STD and LTD coverage will continue for three months after the date you last actively worked, subject to continued payment of the STD premium.
To Apply for Disability Benefits

You should apply for STD benefits as soon as you are aware that your absence will extend beyond 14 days. You should apply for LTD benefits as soon as you know that your disability will extend beyond 90 consecutive days.

You apply for STD benefits by calling The Hartford Insurance Company to begin the claim process. If your claim is approved and you begin receiving STD payments, after 90 days your claim will be automatically transferred to the LTD claim area for handling, provided you are still disabled.

To apply for LTD benefits only, complete and return the Application for Long-Term Disability Income Benefits (available on the Benefits website at http://benefits.jhu.edu/health-and-life/disability.cfm/Hartford_LTD.pdf) to the LTD insurance company:

Benefit Management Services
The Hartford
P.O. Box 14306
Lexington, KY 40512-4306

When you apply for either STD or LTD benefits, you will need to provide the following as proof of your disability:

• The cause of your disability, the date it began and the prognosis;
• Proof that you are receiving appropriate and regular care for your condition from a doctor who is not a member of your immediate family, and whose specialty or expertise is appropriate for your condition;
• The extent to which your disability prevents you from performing your regular occupation; and
• The name and address of the doctor, health care facility or hospital where you are being treated for your condition.

If proof of your disability is not provided within 30 days, your STD benefits may be suspended or terminated. For LTD benefits, proof of disability must be given no later than one year after the end of your 90-day elimination period, unless you are legally incapacitated. On a periodic basis, you may be asked to submit proof of your ongoing disability to the LTD insurance company. You are responsible for the cost of providing this information. In addition, the insurance company has the right to have you examined, at its expense, as often as necessary while your disability claim continues.

Assignment, Subrogation and Reimbursement

You may not assign your STD or LTD benefits to another individual or organization. This means you may not transfer your benefits to someone else. In addition, the insurance company reserves any and all rights to subrogation and/or reimbursement to the fullest extent allowed by law and customary practice. The insurance company also reserves the right to recover any overpayment made by the plans.
# For Other Information, Go To…

| The Big Picture                                                                 | For general information about JHU’s benefits program and how the myChoices Program works |
| Changes to Your Benefits                                                        | For information on how changes in family or work situations may affect your coverage     |
| Administrative Information                                                      | For important facts about STD and LTD plan administration, and your rights under ERISA  |
| Resources                                                                      | For a list of contacts and available resources                                           |
Chapter 8 – Faculty and Staff Assistance Program

**FAST FACTS**

- Appointments for the Faculty and Staff Assistance Program (FASAP) can be scheduled at any office location by calling **443-997-7000**.
- FASAP clinical office locations include:
  - East Baltimore Campus;
  - Johns Hopkins at Eastern;
  - Bayview Campus; and
  - Clinical services are also available in Montgomery County, Howard County and in the Washington, DC metropolitan area.
- More information is available online at [www.fasap.org](http://www.fasap.org).

The Faculty and Staff Assistance Program (FASAP) provides access to assessment, brief counseling and referral services for a variety of common problems, including:

- Problems of daily living;
- Depression, anxiety and other mental health problems;
- Alcohol and other substance abuse and addiction problems;
- Coping with change, loss, grief and mourning;
- Family and relationship difficulties;
- Personal or work-related stress;
- Career and work problems;
- Disruptive workplace behaviors; and/or
- Financial problems.

**Program Overview**

The Faculty and Staff Assistance Program (FASAP) serves faculty, staff and employees, offering:

- Free and confidential professional support services for problems of daily living and emotional well-being; and assessment of mental health problems and services, similar to the EAP model;
- On-site crisis response and support for critical incidents;
- Workplace violence and risk assessment guidance and support to create a safe and healthy workplace; and
- Special expertise in supporting professionals with impairment, substance abuse or behavior challenges.

FASAP clinicians consult with faculty, directors and those in supervisory roles to help resolve interpersonal conflicts between co-workers. The office supports those who lead and manage employees in the midst of performance and interpersonal conduct problems that may be referred to FASAP for counseling and problem-solving support.
Eligibility

FASAP services are available to you if you are a full-time or part-time benefits-eligible employee. FASAP benefits are also available to spouses, domestic partners, significant others and benefits-eligible children of employees.

Enrollment

FASAP benefits are available starting on your date of hire. There are no enrollment forms to complete — coverage is automatic. FASAP services remain available for an additional 30 days following the month of your termination of employment.

Participation

Participation in FASAP is voluntary. Your participation will not affect future employment or career advancement, nor will it protect you from appropriate disciplinary action. You may make an appointment with FASAP for yourself and/or your family. Family members, colleagues and others may also refer you to FASAP.

As a condition of employment, supervisors have the authority to make the following types of FASAP referrals:

- **Mental health/psychological evaluation referrals**: based on the belief that behavioral difficulties or medical or substance abuse problems are causing the decline in job performance. Sometimes this evaluation is needed to determine if the employee is fit for duty.
- **For cause testing**: to determine if alcohol or illegal drugs are present in individuals while working. Medical tests can be requested by the supervisor if he/she has information or evidence the individual may be under the influence.

You must sign a Consent for Services Agreement form with FASAP at the initiation of services.

Scheduling an Appointment

To schedule an appointment with a FASAP clinician, please call **443-997-7000**. You may choose from the following appointment locations:

- East Baltimore Campus, Suite 507, 550 North Broadway;
- Homewood Campus, Eastern High School, 1101 East 33rd Street, Suite C-100;
- Johns Hopkins Bayview Medical Center Campus, 5300 Alpha Commons Drive, Occupational Health Service, Suite 105; and/or
- Montgomery County, Howard County, or the Washington DC metropolitan area.

You will be asked to provide your name and both your work and home phone numbers (in case you need to be contacted prior to your appointment).

You will need to complete some paperwork to proceed with services. You can complete this paperwork at the time of your first appointment.

FASAP services are available from 8:00 a.m. to 6:00 p.m. Monday through Friday. A licensed counselor is available 24 hours a day at **443-997-7000**. For counseling after hours, simply follow the instructions on the voicemail to speak directly with a counselor.
FASAP works closely with Security and the JHH Emergency Room. Those numbers are:

- JHH Emergency Room: **410-955-2280**
- Security: East Baltimore Campus: **410-955-5585**
- Security: Homewood Campus: **410-516-7777**.

**How It Works**

At the initial appointment, the FASAP clinician will:

- Explain policies and procedures
- Listen to your reason(s) for making an appointment with a clinician
- Conduct an assessment
- Make recommendations that address your concerns
- Refer you to community resources if assistance is needed beyond what FASAP can provide

Information will only be provided to outside parties with the written permission of you or your eligible dependent, except as may be permitted by applicable State and Federal law.

**Services Not Covered**

FASAP is intended to be a starting place for addressing problems of daily living that may impact one’s ability to perform at work. This may include identifying mental health and substance abuse problems and making recommendations for further support. FASAP provides counseling for challenges of daily living; for treatment of more serious mental health and substance abuse problems, you will be referred outside of FASAP. While you are not charged for FASAP services, you can be charged for services to which you are referred. Your JHU medical plan or other health insurance may help pay for the services provided by the provider or program to which you are referred.

*Please note: FASAP is not an "employee health plan" for purposes of federal law. This is because when FASAP determines that an individual might benefit from health care services, FASAP simply refers the individual to an appropriate health care provider. The cost of any services provided by that health care provider may or may not be covered by a health plan in which the individual participates. The counseling services provided by FASAP are not health care-related but instead are related to issues of daily living.*

**When Coverage Ends**

FASAP coverage for you and your dependents will end when:

- Your employment terminates;
- You no longer meet the eligibility requirements; or
- JHU stops providing FASAP.

If you have been terminated, you remain eligible for FASAP services for 30 days after the month of your termination. For example, if you are terminated on October 10, you are eligible for FASAP services until November 30.
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</tbody>
</table>
Chapter 9 – Medical and Dental Benefits for Retirees

**FAST FACTS**

Please note: JHU retains the right to terminate or amend its retiree medical and dental plans at any time and at its discretion, even for those who are currently covered.

- You may continue your medical and dental coverage after you retire under the Retiree Health Plan, as long as: (1) you leave JHU in good standing, and (2) at the time you leave JHU you are at least age 55 with 10 years of continuous full-time service or have completed at least 30 years of continuous full-time service.
- JHU may pay a portion (called a subsidy) of the cost of your retiree medical coverage depending upon your age, length of service, and year of retirement. You pay the full cost of retiree dental coverage.
- If you want to continue your medical and dental coverage, you must enroll within 30 days of your retirement—you may cover yourself, your spouse domestic partner, and/or your dependent children.
- Most medical and dental plan options under the Retiree Health Plan are the same as the options available to active employees at the time you retire.
- Once you or your spouse reach age 65, you or your spouse must enroll in Medicare Part B; claims must be submitted to Medicare first, JHU’s retiree medical plan pays secondary.

Having adequate health care coverage is an important consideration when you retire. JHU offers retiree medical and dental coverage for eligible retirees and their eligible dependents—the same coverage available to active employees and their families—as long as the retiree meets certain eligibility criteria for age and service.

If you are enrolled, your coverage as an active eligible employee stops at the end of the month in which you terminate your employment. You are responsible for all or a portion of the cost of your retiree medical coverage based on your age and service with JHU at the time you retire. You are responsible for the full cost of retiree dental coverage. Medical and dental premiums are reviewed annually and will be adjusted based on health care costs and consistent with national trends. You are responsible for future increases to the cost of coverage.

**Eligibility**

You are eligible for retiree medical and dental coverage as long as you:

- Retire from JHU in good standing;
- Are at least 55 years old at the date of your retirement; and
- Have 10 or more years of continuous full-time service with JHU immediately prior to your retirement.

You are also eligible for retiree medical and dental coverage regardless of your age as long as you have completed at least 30 years of continuous full-time service with JHU immediately prior to your retirement. Please note: A leave of absence from which you do not return to full-time service does not count toward
Your spouse or domestic partner* and benefits-eligible dependent child(ren) are also eligible for coverage as long as they satisfy JHU’s eligibility rules for dependent coverage. Your family members are not eligible to participate in any coverage in which you are not enrolled (except as provided for surviving family members who are eligible to continue coverage following your death as described under “Changes in Coverage” later in this chapter). (See “Eligibility and Participation” in Chapter 1, “The Big Picture.”)

*Must qualify for coverage under the JHU Domestic Partner Benefits Policy, as described in Chapter 1, “The Big Picture.”

### Participation

At least three months prior to retirement you should notify the Benefits Service Center of your intent to retire and arrange to meet with one of the retirement specialists. They will provide you with the necessary information and paperwork to enroll in retiree health insurance. For those that don’t meet with a retirement specialist, enrollment paperwork will be mailed out once the retirement termination has been processed.

If you want to elect medical and/or dental benefits, you must actively enroll within 30 days after you receive your enrollment paperwork. You will not be required to provide a Statement of Health. Because your coverage as an active employee ends the last day of the month in which you retire, there will be no “gap” in your coverage.

*Please note: If you have medical and/or dental coverage as an active employee on your retirement date, you will not be automatically enrolled in medical coverage or in dental coverage.*

If you decide to enroll in retiree medical or dental coverage, you may elect individual coverage or you may elect to cover yourself plus any spouse, domestic partner or child who is eligible for the same coverage at that time.

If you decide to waive medical or dental coverage at retirement because you have coverage elsewhere (excluding Medicare), you will have the opportunity to enroll at a later date if you lose that alternative coverage. See “Changes in Coverage” in this chapter.

### Changes in Coverage

If you drop (or waive) retiree medical or dental coverage for yourself or any eligible family member because of alternative coverage and you wish to enroll yourself or any affected eligible family member in the JHU retiree medical or dental coverage on a later date, you must provide proof of loss of the alternative coverage and you must request enrollment within 30 days after alternative coverage ends.

If you marry or enter into a domestic partnership while enrolled in retiree coverage, you will have the opportunity to enroll your new spouse or domestic partner and any eligible dependent child in the medical or dental plans in which you are currently participating within 30 days of the marriage or domestic partnership.

If you die while covered under retiree coverage, your covered spouse or domestic partner is eligible to remain enrolled in JHU’s retiree medical or dental plans for his/her lifetime. If he/she re-marries or begins a domestic partnership, the new spouse or domestic partner would not be eligible to enroll in the plans. Your covered child(ren) may remain in the plans until they no longer meet the plan’s dependent eligibility requirements. At the time of enrollment, your health coverage rate will follow the current rate structure.
Discontinuing Retiree Health Plan

If you enroll at retirement and you later wish to discontinue retiree medical or dental coverage, you must notify the Benefits Service Center in writing. If at any time you (or your surviving family member following your death) fail to make a payment for coverage within 30 days of the payment due date, that coverage will be automatically dropped retroactive to the last day of the previous month.

Cost of Coverage

JHU contributes toward, or subsidizes, the cost of retiree medical coverage in varying amounts depending upon the age of the retiree, length of service and year of retirement.

Please note: If you are an eligible retiree who retired before 2006, different rules apply in determining if you are eligible for a subsidy for medical coverage.

Retirees who retired in 2006 or later and who are eligible for retiree medical must meet the “Rule of 75” to be eligible for a medical premium subsidy from JHU. This means that if the covered retiree’s age and eligible service (when added together) equals or exceeds 75, JHU will subsidize a fixed amount of the retiree medical premium costs annually. If age and service is less than 75, the covered retiree is not eligible for the subsidy, and must pay the full premium cost for coverage. If age and service equals or exceeds 80, the covered retiree is eligible for the maximum subsidy.

<table>
<thead>
<tr>
<th>Age Plus Service</th>
<th>% of Medical Premium Subsidy* Paid by JHU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 75</td>
<td>None—participant pays full premium cost</td>
</tr>
<tr>
<td>75</td>
<td>25%</td>
</tr>
<tr>
<td>76</td>
<td>40%</td>
</tr>
<tr>
<td>77</td>
<td>55%</td>
</tr>
<tr>
<td>78</td>
<td>70%</td>
</tr>
<tr>
<td>79</td>
<td>85%</td>
</tr>
<tr>
<td>80 or more</td>
<td>100% of maximum subsidy</td>
</tr>
</tbody>
</table>

*Note: See table below for maximum subsidy amounts.

The table below shows the maximum subsidy amount JHU will pay toward medical coverage. The subsidy changes when the covered retiree becomes Medicare-eligible and does not adjust should the covered retiree’s spouse become Medicare-eligible first. Keep in mind that because the subsidy is a fixed amount, the covered retiree’s share of the retiree medical premium will grow over time as medical premiums increase.
Medical and Dental Benefits for Retirees

Medical premium costs vary by plan (e.g., CareFirst BlueCross BlueShield Medical, EHP Classic) and coverage level (e.g., Individual, 2 Adults). Premium costs change each year based on claims experience but the subsidy remains a fixed amount. Thus, covered retirees are responsible for any future increases in premium costs.

If you qualify for and timely elect the retiree medical and dental coverage, you will be billed monthly for your portion of the cost of the benefits by JHU’s billing service.

**Example—Calculating the Cost of Coverage**

Let’s say that you are single, considering retirement and are 62 years old with 15 years of continuous full-time service. Here’s how to calculate the cost of your medical premium:

**Step 1**  Your age + service = 62 + 15 = 77.

**Step 2**  Table 1 indicates that you are eligible for 55% of the maximum subsidy amount from JHU.

**Step 3**  55% x $2,496/year (from Table 2, individual coverage, non-Medicare-eligible) = $1,372.80/yr. = JHU’s share of your premium.

**Step 4**  The 2013 retiree medical premium for individual coverage under the CareFirst BlueCross BlueShield Medical is: $7,876.00/yr.

**Step 5**  Your cost of coverage is equal to the difference between the 2013 retiree medical premium ($7,876.00) and JHU’s share of your premium ($1,372.80): $6,503.20/yr.

So, the amount JHU will pay toward your medical premium annually is $1,372.80. You will be responsible for paying the remaining cost of your medical premium, which is $6,503.20/yr.

**When Prior Service Counts Toward Medical Subsidy**

If you leave JHU and return, you must meet the eligibility requirements stated above, including having 10 or more years of continuous full-time service immediately prior to your retirement.

For your previous service to count toward the medical subsidy, your prior service must be in blocks of 10 or more years of continuous full-time service.

**Coordinating With Other Health Care Coverage**

If you or your eligible dependents have any other health coverage, JHU’s retiree medical benefits will coordinate with other plans to prevent duplication of payment. Read more about how coordination of benefits works in “Medical Benefits.”
Effect of Medicare

JHU’s medical coverage for retirees and those covered through them is automatically coordinated with benefits provided by (or that would be provided by if the individual enrolled) Medicare Parts A and B. Please note that JHU’s retiree medical coverage for any Medicare-eligible individual will automatically coordinate with Medicare whether or not the covered individual has enrolled. Once you or an individual covered through you becomes eligible for Medicare, Medicare is treated as the primary plan (pays benefits first). JHU’s retiree medical coverage then pays any remaining covered expenses beyond what is paid (or would be paid) by Medicare Parts A and B, up to the plan’s eligible allowable expense.

Once you are eligible for Medicare, you are also eligible to enroll in a Medicare Prescription Drug plan (also known as Medicare Part D), which is an optional plan that provides prescription drug benefits. If you enroll in retiree medical coverage with JHU, enrolling in Medicare Part D generally will not provide any significant additional benefits or advantages for most people, but it is up to you to determine if that is true for you. While you are covered under the retiree medical coverage, you will receive a notice from JHU each year that lets you know whether JHU’s prescription drug benefits are at least as good as the standard Medicare Part D benefits.

Filing Claims

Until you become eligible for Medicare, you should file claims as described in the Administrative Information section of this document. Once you become eligible for Medicare, however, your medical claims will be processed as if they were submitted to Medicare first, so you should enroll in Medicare Parts A and B as soon as possible. Any claims that Medicare does not or would not cover in full may be submitted to JHU’s retiree medical plan for processing (and payment on a secondary basis to the extent that the expenses are covered under the terms of the plan).

If You Are Rehired

If, at any time, you are rehired by JHU as a full-time benefits-eligible employee, you will no longer be eligible for retiree medical and/or dental coverage. Instead, you will be eligible to participate in the myChoices Program. You must re-enroll in the retiree health coverage when your full-time employment again terminates if you wish to continue your health coverage under JHU’s Retiree Health Plan. Current rates will apply.

If you are rehired by JHU as a part-time or limited-time employee, JHU’s Retiree Health Plan becomes the primary coverage and if applicable, Medicare becomes secondary coverage for the duration of that employment. You must notify the Benefits Service Center of any part-time or limited-time reemployment that may affect Medicare’s primary insurer status.

When Coverage Ends

If you or your spouse or child ceases to be eligible to remain on JHU’s retiree medical and dental plans because of your divorce or separation or a loss of dependent status or if your child ceases to satisfy the eligibility requirements for dependent coverage (or in certain other cases), your covered dependents may be able to choose to continue medical and dental coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Whenever this is applicable, COBRA information and enrollment instructions will be sent to your home address or to the address that is provided.
For Other Information, Go To...

<table>
<thead>
<tr>
<th>The Big Picture</th>
<th>For general information about JHU’s overall benefits program and how the Retiree Health Plan works</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>For information on COBRA</td>
</tr>
<tr>
<td>Administrative Information</td>
<td>For important facts about Retiree Health Plan administration and the rights you may have under ERISA</td>
</tr>
<tr>
<td>Resources</td>
<td>For contact information of plan vendors</td>
</tr>
</tbody>
</table>
Chapter 10 – Administrative Information

This Summary Plan Description is intended to provide you with accurate and easy-to-understand information about Johns Hopkins University welfare benefits. It includes a summary of JHU welfare benefit plans and programs and important information you need to understand your benefits.

JHU sponsors two welfare plans: The JHU Welfare Plan and the JHU Retiree Health Plan. The Welfare plans allow you to choose between several benefits or “component plans.”

The JHU Welfare Plan is a form of employee welfare benefit plan called a “cafeteria plan” because it allows you to choose the benefits you will receive from the Plan. You are given the opportunity to direct the employer to reduce your salary by a specified amount. You then can use the amount of the salary reduction to purchase benefits under the Plan. For certain benefits, because your salary is reduced before federal taxes (and, in most states, State taxes) are imposed, you pay less in taxes if you participate in the Plan. (Some benefits may require that you make after-tax contributions.)

The JHU Retiree Health Plan allows eligible retirees to select between medical and dental benefits. Participants in the Retiree Health Plan are only eligible to participate in the medical and dental component plans.

The official plan documents and contracts contain full details of the legal provisions of each welfare and component plan. In case of a conflict between the official plan documents, the summaries provided here in the Summary Plan Description, any other written materials, or any oral statements made to you concerning your benefits, the official plan documents will govern.

The Plans will provide benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns’ and Mothers’ Health Protection Act (NMHPA), the Women’s Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and all relevant provisions of the Patient Protection and Affordable Care Act (PPACA).

You may review or obtain copies of the official plan documents. To receive copies, contact the Benefits Service Center via email at benefits@jhu.edu, or call 410-516-2000. Office hours are Monday through Friday, 8:30 am – 5:00 pm.

The Johns Hopkins University
Benefits Service Center (Eastern)
1101 East 33rd Street, Suite D200
Baltimore, MD 21218
Fax: 1-443-997-5820

Plan Amendment or Termination

JHU reserves the right to amend, modify or terminate, at any time and for any reason, any or all of the welfare or component plans and programs described in these materials, including with respect to any retirees that are already enjoying retiree benefits. JHU also has the right to institute or change the level of employee contributions for any of these benefits. You will be notified of any change.
ERISA Information

Participants in particular JHU benefit plans and their beneficiaries receiving benefits are entitled to certain rights and protections under a federal law known as the Employee Retirement Income and Security Act of 1974, as amended (ERISA).

The following JHU benefits are provided under ERISA plans:

- Medical
- Dental
- Health care flexible spending account
- Life Insurance (basic, supplemental and dependent)
- Accidental death and dismemberment insurance
- Business travel accident insurance
- Long-term disability
- Short-term disability

The following JHU plans/programs are not covered by ERISA:

- Dependent care flexible spending account
- myChoices Program
- Faculty and Staff Assistance Program

The remainder of this section provides important administrative information about JHU's ERISA plans and summarizes your rights under ERISA as a plan participant. The administrative facts and other information provided in this section, together with all of the other information provided in this document describing ERISA plan benefits, constitute the Summary Plan Descriptions for JHU’s ERISA plans.

The Johns Hopkins University Welfare Plans

Plan Name: The Johns Hopkins University Welfare Plan
Plan Number 501
Plan Year: January 1 through December 31
The Plan is a “cafeteria plan” in which participants can use either pre-tax or after-tax dollars to choose between different welfare component plans.

The Johns Hopkins University Retiree Health Plan
Plan Number 514
Plan Year: July 1 through June 30
The Plan is a welfare plan in which participants can use after-tax dollars to choose between different welfare component plans.

Plan Sponsor: The Johns Hopkins University
Johns Hopkins at Eastern
1101 E. 33rd Street, Suite D200
Baltimore, Maryland 21218

Employer Identification Number: 52-0595110
Plan Administrator: The Johns Hopkins University. Plan Administrator correspondence should be mailed to:

The Johns Hopkins University
Office of Benefits Services
Johns Hopkins at Eastern
1101 E. 33rd Street, Suite C020
Baltimore, Maryland 21218

Telephone number: 410-516-2000
E-mail: benefits@jhu.edu

Plan Agent for Service of Legal Process: The Vice President of Human Resources, whose address is the same as the University’s address. Process may also be served on the Plan Administrator.

Funding Medium: Plan benefits are provided through a mix of insurance contracts or from the Employer’s general assets.

Source of Contributions: The contributions for the plans are a mixture of employer and employee contributions.
## Component Plans Under The Johns Hopkins University Welfare Plan and The Johns Hopkins University Retiree Health Plan

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Type of Plan</th>
<th>Type of Administration</th>
<th>Claims Administrator or Plan Insurer</th>
</tr>
</thead>
<tbody>
<tr>
<td>JHU BlueCross BlueShield Plan (CareFirst BlueCross BlueShield Medical and CareFirst BlueCross BlueShield Plan III)</td>
<td>An employee welfare plan providing medical, dental, and prescription drug benefits.</td>
<td>The Plan Administrator manages the plan on a day-to-day basis and resolves questions about plan details and eligibility for benefits; the administration of the benefit plan is provided through a Claims Administrator.</td>
<td>The plan is not insured. The Claims Administrator is: CareFirst BlueCross BlueShield (CareFirst). 10455 Mill Run Circle Owings Mills, MD 21117 410-581-3000</td>
</tr>
<tr>
<td>JHU Employee Health Plan (EHP)</td>
<td>An employee welfare plan providing medical and prescription drug benefits.</td>
<td>The Plan Administrator manages the plan on a day-to-day basis and resolves questions about plan details and eligibility for benefits.</td>
<td>The plan is not insured. The Claims Administrator is: JHU Employer Health Programs 6704 Curtis Court Glen Burnie, MD 21060 410-424-4450 800-261-2393</td>
</tr>
<tr>
<td>JHU Health Maintenance Plan (BlueChoice HMO*)</td>
<td>An employee welfare plan providing medical and prescription drug benefits.</td>
<td>The plan is administered by CareFirst BlueChoice Inc. through an insurance contract.</td>
<td>The plan is insured. The Insurer is: Kaiser Permanente 2101 East Jefferson Street Rockville, MD 20852 ATTN: Member Services Appeals Unit 800-777-7902</td>
</tr>
<tr>
<td>JHU Health Maintenance Plan (Kaiser Permanente HMO)</td>
<td>An employee welfare plan providing medical, and prescription drug benefits.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The JHU Health Maintenance Plan (CareFirst BlueChoice) is available only to certain participants. Please contact the Benefits Service Center for more information.*
### Funding

<table>
<thead>
<tr>
<th></th>
<th>Claims are paid from the general assets of JHU.</th>
<th>Claims are paid from the general assets of JHU.</th>
<th>Benefits are paid from the general assets of JHU.</th>
<th>Benefits are insured by Kaiser Permanente.</th>
</tr>
</thead>
</table>

### Appeals Process

<table>
<thead>
<tr>
<th></th>
<th>Claims appeals are handled by CareFirst BlueCross BlueShield; appeals related to eligibility, enrollment, and qualifying event changes are handled by the JHU Benefits Appeals Committee.</th>
<th>Claims appeals are handled by EHP; appeals related to eligibility, enrollment, and qualifying event changes are handled by the JHU Benefits Appeals Committee.</th>
<th>Claims appeals are handled by CareFirst BlueChoice; appeals related to eligibility, enrollment, and qualifying event changes are handled by the JHU Benefits Appeals Committee.</th>
<th>Claims appeals are handled by Kaiser Permanente; appeals related to eligibility, enrollment, and qualifying event changes are handled by the JHU Benefits Appeals Committee.</th>
</tr>
</thead>
</table>

### Component Benefit Plans Under The Johns Hopkins University Welfare Plan

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>JHU Group Dental Plans</th>
<th>JHU Group Life Insurance Plan</th>
<th>JHU Business Travel Accident Insurance Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Plan</strong></td>
<td>An employee welfare plan providing dental benefits.</td>
<td>An employee welfare plan providing life insurance benefits.</td>
<td>An employee welfare plan providing travel accident insurance benefits.</td>
</tr>
<tr>
<td><strong>Type of Administration</strong></td>
<td>The administration of the benefit plan is provided through a Claims Administrator identified below.</td>
<td>The plan is administered by Securian Financial Group through an insurance contract.</td>
<td>The plan is administered by The Hartford Insurance Company through an insurance contract.</td>
</tr>
<tr>
<td>Claims Administrator or Plan Insurer</td>
<td>The CareFirst BlueCross BlueShield (CareFirst) and CIGNA plans are not insured. CareFirst, CIGNA, and United Concordia are the Claims Administrators for the benefit plans. The address and telephone numbers are: CareFirst BlueCross BlueShield 10455 Mill Run Circle Owings Mills, MD 21117 410-581-3000 CIGNA Dental Health Inc. 900 Cottage Grove Road Hartford, CT 06152 888-336-8258 United Concordia 4401 Deerpath Road Harrisburg, PA 17110 866-357-3304</td>
<td>Securian Financial Group 400 Robert Street North St. Paul, MN 55101 888-658-0193</td>
<td>The Hartford Insurance Company 200 Hopmeadow Street Simsbury, CT 06089 800-303-9744</td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Funding</td>
<td>Benefits are paid from the general assets of JHU on behalf of the plan in accordance with a contract with CareFirst BlueCross BlueShield and CIGNA; benefits are insured by United Concordia.</td>
<td>Benefits are insured by Securian Financial Group.</td>
<td>Benefits are insured by The Hartford Insurance Company.</td>
</tr>
<tr>
<td>Appeals Process</td>
<td>Claims appeals are handled by CareFirst BlueCross BlueShield, CIGNA, or United Concordia; appeals related to eligibility, enrollment and qualifying event changes are handled by JHU Benefits Appeals Committee.</td>
<td>Claims appeals are handled by Securian Financial Group; appeals related to eligibility, enrollment and qualifying event changes are handled by JHU Benefits Appeals Committee.</td>
<td>Claims appeals are handled by The Hartford Insurance Company.</td>
</tr>
</tbody>
</table>
### Component Benefit Plans Under The Johns Hopkins University Welfare Plan (Continued)

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Type of Plan</th>
<th>Type of Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>JHU Group Long-Term Disability Plan</td>
<td>An employee welfare plan providing long-term disability insurance benefits.</td>
<td>The plan is administered by the Plan Administrator through an insurance contract purchased from The Hartford; certain ministerial functions are performed on behalf of the plan by The Hartford; these functions include, but are not limited to, administration and payment of claims, determination of your eligibility under the plan, premium billing and policy and certificate issuance.</td>
</tr>
<tr>
<td>JHU Group Short-Term Disability Plan</td>
<td>An employee welfare plan providing short-term disability insurance benefits.</td>
<td>The plan is administered by the Plan Administrator through an insurance contract purchased from The Hartford; certain ministerial functions are performed on behalf of the plan by The Hartford; these functions include, but are not limited to, administration and payment of claims, determination of your eligibility under the plan, premium billing and policy and certificate issuance.</td>
</tr>
<tr>
<td>Health Care Flexible Spending Account</td>
<td>An employee welfare benefit plan providing health benefits.</td>
<td>The plan is administered by JHU.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claims Administrator or Plan Insurer</th>
<th>The Hartford Life Group Insurance Company</th>
<th>The Hartford Life Group Insurance Company</th>
<th>WageWorks is the Claims Administrator for the benefit plan. The address and telephone number for WageWorks is:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>200 Hopmeadow Street, Simsbury, CT 06089 800-303-9744</td>
<td>200 Hopmeadow Street, Simsbury, CT 06089 800-303-9744</td>
<td>WageWorks, Inc. 1100 Park Place, 4th Floor San Mateo, CA 94403 877-924-3967 <a href="http://www.wageworks.com">www.wageworks.com</a></td>
</tr>
</tbody>
</table>

WageWorks is the Claims Administrator for the benefit plan. The address and telephone number for WageWorks is:

WageWorks, Inc.
1100 Park Place, 4th Floor
San Mateo, CA 94403
877-924-3967
www.wageworks.com
<table>
<thead>
<tr>
<th>Funding</th>
<th>Benefits are funded through an insurance contract issued by The Hartford.</th>
<th>Benefits are funded through an insurance contract issued by The Hartford.</th>
<th>Benefits are paid from the general assets of JHU.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeals Process</td>
<td>Claims appeals are handled by The Hartford; appeals related to eligibility, enrollment and qualifying event changes are handled by JHU Benefits Appeals Committee.</td>
<td>Claims appeals are handled by The Hartford; appeals related to eligibility, enrollment and qualifying event changes are handled by JHU Benefits Appeals Committee.</td>
<td>Claims appeals are handled by WageWorks; appeals related to eligibility, enrollment and qualifying event changes are handled by JHU Benefits Appeals Committee.</td>
</tr>
</tbody>
</table>

**ERISA Rights**

As a plan participant, you are entitled to certain rights and protections under the federal law known as the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to the rights outlined below.

**Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator’s office during normal business hours and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for copying and mailing the documents.

Receive a summary of the plans’ annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of these summary annual reports.

**Continue Group Health Plan Coverage**

You are entitled to continue health care coverage for yourself, your spouse, your domestic partner or dependents if there is a loss of coverage under the plan as a result of a COBRA qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
You are entitled to the reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan.

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension or welfare benefit or exercising your rights under ERISA.

**Enforce Your Rights**

If your claim for a pension or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and 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. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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.

**Assistance with Your Questions**

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
**Allocation of Fiduciary Responsibility**

The Plan Administrator for each ERISA plan has full power and discretionary authority to administer the applicable benefit plan. This includes, but is not limited to, discretionary authority to determine all questions relating to eligibility to participate in, be covered by, and receive a benefit under the plans. With respect to certain of its benefit plans, the Plan Administrator has delegated its fiduciary authority for claim determinations to each plan’s named Claims Administrator or Plan Insurer. In exercising its fiduciary responsibility, the Claims Administrator or Plan Insurer has discretionary authority to make factual determinations to determine with final authority whether or, and to what extent, employees and their dependents are entitled to benefits, and to construe plan terms.

Any exercise of discretionary authority that has been granted to a plan fiduciary is final and binding on participants, beneficiaries, and any other interested party.

**Claims and Appeals Procedures**

The following summary of the plan’s claims procedures is intended to reflect the Department of Labor’s claims procedure regulations and for medical benefits, the applicable requirements of regulations issued under the federal health care reform law (the Affordable Care Act), and should be interpreted accordingly. If there is any conflict between this summary and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the plan automatically effective on the date of those changes.

For any insured benefits, the insurer’s claims procedures generally will apply instead of the claims procedures described in this document. However, to the extent that the insurer’s claims procedures do not comply with applicable law, the procedures in this document will apply instead of the Insurer’s procedures. The insurer’s claims procedures are described in separate benefit booklets that describe the specific benefit. If you have questions about claims procedures for any insured benefit, you should contact the insurer directly.

To receive plan benefits, you must follow the procedures established by the Plan Administrator and/or the insurance company that has the responsibility for making the particular benefit payments to you. If you do not follow the plan’s claims procedures, you may lose your right to a benefit under the plan, including any right you may have to file a legal action for benefits.

*Please note: The plan’s decisions on claims or appeals are based solely on whether or not benefits are available under the plan for the proposed treatment or procedure. Any decision about whether you proceed with any health service is between you and your health care provider.*

**Adverse Decisions**

For purposes of this claims procedure section, an “adverse decision” is any denial, reduction, termination of or failure by the plan to provide or make payment (in whole or in part) for, a benefit, including any such decision that is based on a determination of an individual’s eligibility to participate in a benefit under the plan. For any coverage that is subject to the Affordable Care Act, “adverse decision” also includes any rescission of coverage. A rescission of coverage generally is a termination of coverage that is retroactively effective for fraud or for misrepresentation of a material fact. Note that a termination of coverage for failure to pay any required contributions is not considered a rescission and is not subject to these claims procedures even if it is effective retroactive to the date through which coverage was paid for. Whether a termination of coverage is considered a “rescission” and is therefore an adverse decision that is subject to these claims procedures will be determined by the reviewer based on applicable law.
Initial Claims

Initial claims for plan benefits are made to the Claims Administrator for the particular benefit. All claims must be submitted, in writing (except to the extent that oral claims are permitted for “urgent care claims,” as described below), to the Claims Administrator. Claims should be submitted promptly after an expense is incurred. Unless a different deadline expressly applies in this document under a benefits booklet or insurance contract, no initial claim for any benefit will be accepted, processed or paid for any expense if the initial claim is submitted later than one year after the date the expense was incurred. (For deadlines for submitting spending account reimbursement requests, see the “Flexible Spending Accounts” section of this Summary.)

You may file claims and appeals through a properly authorized representative. The Claims Administrator generally will communicate directly with any authorized representative. References in these claims procedures to “you” or “your” should be understood as referring to the covered person who is the subject of the applicable claim or, if applicable, any person properly acting as an authorized representative on behalf of that covered person.

The rules for filing claims and appeals of any adverse decisions vary depending on the type of benefit, with separate rules for health care benefits, disability benefits and other benefits.

Claims for Health Care Benefits (Medical and Dental) and Health Care Spending Account Benefits

The claims procedures for health care benefits vary depending on whether the claim is submitted before or after health care services have been provided. Most claims are filed only after services have been provided and are considered “post-service claims.” For some benefits, you are required to obtain advance approval of the benefit before medical care is provided. Those types of claims are considered “pre-service claims.” Finally, certain types of pre-service claims are considered “urgent care claims” because medical circumstances may require a quick decision on the claim. The rules for each of these types of health care claims follow.

Special claims procedure rules apply to health coverage that is subject to the Affordable Care Act, as described in this Claims Procedure section. Generally, medical coverage (including prescription drug coverage and any other benefits that are included with the medical coverage that you select) is subject to the Affordable Care Act, but health care spending accounts and separate dental coverage are not subject to that Act.

A health care claim is considered a post-service claim if it is a request for payment for services or other benefits already provided (or any other health benefit claim for which the plan does not condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care). All health care spending account claims are post-service claims.

If your post-service claim is denied, you will receive a written or electronic notice from the Claims Administrator within a reasonable period of time, but not later than 30 days after receipt of the claim, as long as all needed information was provided with the claim. This 30-day period may be extended for up to 15 days, if the Claims Administrator:

• Determines the extension is necessary because of matters beyond the plan’s control, and
• Notifies you, before the end of the 30-day period, why the extension is needed and the expected decision date.

If such an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information and you or your authorized representative will have 45 days from receipt of the notice to provide any missing information necessary to
decide your claim. If all of the needed information is received within the 45-day timeframe and the claim is
denied, the Claims Administrator will notify you of the denial within 15 days after the information is received.
If you don’t provide the needed information within the 45-day period, your claim will be evaluated based on
the information available to the Claims Administrator at the time.

Notice of Adverse Decision

For any health care claim, any notice of the plan’s adverse decision will include:

- A description of the specific reason or reasons for denial with reference to any specific plan provisions on
  which the denial is based;
- A description of any additional material or information necessary to perfect the claim and an explanation
  of why the material or information is necessary;
- A description of the plan’s appeal procedures and timeframes, including a statement of your right to bring
  a civil action under section 502(a) of ERISA following an adverse decision on appeal;
- If applicable, a copy of any internal rule, guideline, protocol or other similar criterion relied upon in making
  the adverse decision, or a statement that such a rule, guideline, protocol or other similar criterion was
  relied upon and that a copy will be provided free of charge upon request; and
- If the adverse decision was based on a medical necessity, experimental treatment or similar exclusion or
  limit, an explanation of the scientific or clinical judgment for the adverse decision applying the terms of the
  plan to your medical circumstances, or a statement that such an explanation will be provided free of
  charge upon request.

In addition, for any adverse decision involving medical coverage that is subject to the Affordable Care Act,
note that the plan will ensure that claims and appeals are decided in a manner designed to ensure the
independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring,
compensation, termination, promotion, or similar matters will not be made based on the likelihood that any
person involved in making claims decisions will support the denial of benefits. Also, any notice of an adverse
decision regarding coverage that is subject to the Affordable Care Act will be provided in a culturally and
linguistically appropriate manner in accordance with applicable law regarding such notices and will include
(in addition to the other notice requirements described above):

- Information sufficient to identify the claim involved, including the date of service, the health care provider
  and the claim amount (if applicable);
- A discussion of the decision, as well as disclosure of any denial code used (and an explanation of its
  meaning) and a description of the plan’s standard, if any, that was used in denying the claim;
- A description of available internal appeals and external review processes, including information regarding
  how to initiate an appeal;
- Information (including contact information) about the availability of any applicable office of health
  insurance consumer assistance or ombudsmen established pursuant to the Affordable Care Act to assist
  individuals with internal claims, appeals and external review processes; and
- A statement describing the availability, upon request, of any applicable diagnosis code (and an
  explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Pre-Service Health Care Claims

Pre-service claims are those claims that require notification or approval before medical care is provided (for
example, pre-certification requirements). If your claim was a pre-service claim (other than an “urgent care
claim”, as described in the next section) and was submitted properly with all needed information, you will
receive a written or electronic notice of the claim decision from the Claims Administrator within a reasonable
time period appropriate to the medical circumstances, but not later than 15 days from receipt of the claim. If
you filed a pre-service claim improperly (not in accordance with the plan’s claim procedures), the Claims
Administrator will notify you of the improper filing and how to correct it as soon as possible, but not later than five days after the pre-service claim was received. The initial 15-day period may be extended for up to 15 days, if the Claims Administrator:

• Determines the extension is necessary because of matters beyond the plan’s control, and
• Notifies you before the end of the 15-day period of why the extension is needed and the expected decision date.

If such an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information and you will have 45 days from the date you receive the notice to provide any missing information necessary to decide your claim. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don’t provide the needed information within the 45-day period, your claim will be evaluated based on the information available to the Claims Administrator at the time. Any notice of an adverse decision will include the same information described under “Notice of Adverse Decision” in the “Post-Service Health Care Claims” section above.

To receive notice of an improperly filed pre-service claim, you must have provided a communication regarding the claim to the person or organizational unit that customarily handles benefit matters for the plan. The communication must include:

• The identity of the claimant;
• A specific medical condition or symptom; and
• A request for approval for a specific treatment, service or product.

**Urgent Health Care Claims**

Urgent care claims are those pre-service health care claims for medical care or treatment that require notification or approval prior to receiving medical care where application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health, the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Claims Administrator will defer to a determination, if any, by a qualified attending provider that a claim qualifies as an urgent care claim based on the definition summarized in the preceding sentence.

For urgent care claims:

• You will receive notice of the benefit determination in writing or electronically as soon as possible taking into account the medical exigencies, but not later than 72 hours after the Claims Administrator receives your claim; and
• Any notice of adverse decision may be oral with a written or electronic confirmation to follow within three days.

If more information is needed to process your claim, the Claims Administrator will notify you of the improper filing and how to correct it as soon as possible, but no more than 24 hours after the urgent care claim was received. Notice of an improperly filed pre-service or urgent care claim may be provided orally — or in writing, if you request. After receiving the notice, you would have a reasonable amount of time taking into account your circumstances, but not less than 48 hours to file a proper claim or provide the requested information.
You will be notified of a determination as soon as possible, but in no event later than 48 hours after:

- The Claims Administrator receives the requested information, or
- The end of the period within which you were to provide the additional information, if the information is not received within that time.

Any notice of an adverse decision will include the same information described under “Notice of Adverse Decision” in the “Post-Service Health Care Claims” section above, as well as a description of any expedited review process applicable to your urgent care claim.

To receive notice of an improperly filed urgent care claim, you must have provided a communication regarding the claim to the person or organizational unit that customarily handles benefit matters for the plan. The communication must include:

- The identity of the claimant;
- A specific medical condition or symptom; and
- A request for approval for a specific treatment, service or product.

**Health Care Concurrent Care Claims**

Concurrent care claims are claims for ongoing treatment that have previously been approved. If the plan has approved an ongoing course of treatment to be provided over a period of time or for a specific number of treatments, any reduction or termination by the plan of such treatment (other than by plan amendment or termination) before the end of that period of time or number of treatments will be considered an adverse decision. The plan will notify you sufficiently in advance to allow you to appeal before the benefit is reduced or terminated.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided and notice provided to you as soon as possible taking into account the medical exigencies, but no later than 24 hours after receipt of your claim, provided that your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as a new urgent care claim and decided according to the timeframes described for urgent care claims.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and your request to extend treatment is not an urgent care claim, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever apply.

**Appeals of Adverse Decisions (for Health Care Claims)**

If you disagree with a claim determination, you may contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include the following:

- The patient’s name and identification number as shown on the medical or dental ID card;
- The dates of medical or dental services;
- The provider’s name;
- The reason you believe the claim should be paid; and
- Any documentation or other written information to support your request for claim payment.

Your appeal of an adverse decision on your initial claim must be submitted to the Claims Administrator within 180 days after you receive the notice of the plan’s adverse decision.
Certain benefits provide for two mandatory levels of internal appeal. Any notice of adverse decision will indicate whether that applies to your claim. Whenever that applies, if you wish to appeal an adverse decision at the first level of appeal, your request for a second level appeal must be submitted to the Claims Administrator within 60 days after you receive the notice of the plan’s adverse decision at the first level of appeal.

For any appeal of an adverse decision, you have the right to:

• Submit for review written comments, documents, records and other information relating to the claim;
• Request and be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
• A review that takes into account all comments, documents, records and other information submitted by you or your authorized representative, without regard to whether such information was submitted or considered in the initial claim decision;
• A review that does not afford deference to the initial adverse decision and that is not conducted by the individual who made the adverse decision or any subordinate of that person;
• If the appeal involves an adverse decision based on medical judgment, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual; and
• Identification of medical or vocational experts, if any, whose advice was obtained by the plan in connection with the claim review, without regard to whether the advice was relied upon in making the decision.

If the appeal involves health coverage that is subject to the Affordable Care Act, you also have the right to review the claim file and to present evidence and testimony, and the plan also will comply with the following additional rules:

• The plan will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the plan in connection with the claim as soon as possible and sufficiently in advance of the plan’s deadline for providing notice of a final denial of a claim (as described in these claims procedures) to give you a reasonable opportunity to respond before that date; and
• Before the plan issues a final decision on review based on a new or additional rationale, you will be provided, free of charge, with the rationale for the plan’s decision as soon as possible and sufficiently in advance of the plan’s deadline for providing notice of a final denial of a claim (as described in these claims procedures) to give you a reasonable opportunity to respond before that date.

You will be provided written or electronic notice (or notice by some other expeditious method for certain urgent care claims described below) of the plan’s decision on your appeal as follows:

• For appeals of urgent care claims, notice of the plan’s decision will be provided as soon as possible taking into account the medical exigencies; no later than 72 hours after the plan receives your request for appeal. If the plan has only one level of appeal, that appeal will be conducted and you will be notified of the reviewer's decision within 72 hours after the plan receives your request for appeal. If the plan has two mandatory levels of appeal, the first level appeal will be conducted and you will be notified of the reviewer’s decision within 36 hours after the plan receives your request for appeal. The second level appeal will be conducted and you will be notified of the subsequent reviewer’s decision within 36 hours from receipt of a request for review of the first level appeal decision. Each appeal will follow the same process described in the immediately preceding section on how to appeal health care claims. The review in each level of appeal will afford no deference to the lower-level adverse decision.
• For appeals of pre-service claims, notice of the plan’s decision will be provided within a reasonable period of time appropriate to the medical circumstances but no later than 30 days after the plan receives your request for appeal. If the plan has only one level of appeal, that appeal will be conducted and you will be
notified of the reviewer’s decision within 30 days after the plan receives your request for appeal. If the plan has two mandatory levels of appeal, the first level appeal will be conducted and you will be notified of the reviewer’s decision within 15 days after the plan receives your request for appeal. The second level appeal will be conducted and you will be notified of the subsequent reviewer’s decision within 15 days from receipt of a request for review of the first level appeal decision. Each appeal will follow the same process described in the immediately preceding section on how to appeal health care claims. The review in each level of appeal will afford no deference to the lower-level adverse decision.

• For appeals of post-service and spending account claims, notice of the plan’s decision will be provided within a reasonable period of time but no later than 60 days after the plan receives your request for appeal. If the plan has only one level of appeal, that appeal will be conducted and you will be notified of the reviewer’s decision within 60 days after the plan receives your request for appeal. If the plan has two levels of appeal, the first level appeal will be conducted and you will be notified of the reviewer’s decision within 30 days after the plan receives your request for appeal. The second level appeal will be conducted and you will be notified of the subsequent reviewer’s decision within 30 days after the plan receives your request for review of the first level appeal decision. Each appeal will follow the same process described in the immediately preceding section on how to appeal health care claims. The review in each level of appeal will afford no deference to the lower-level adverse decision.

If the plan makes an adverse decision on your appeal, you will receive written or electronic notice of that decision, which will include:

• A description of the plan’s decision, including any specific reasons for denial and references to any plan provisions on which the denial is based;

• A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim or appeal;

• A description of any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring a court action under section 502(a) of ERISA;

• If applicable, a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and that a copy will be provided free of charge upon request; and

• If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such an explanation will be provided free of charge upon request.

For procedures associated with urgent care claims, see “Claims Decision Appeal: Urgent Care Claims That Require Immediate Action,” which follows.

Your second level appeal request must be submitted to EHP within 60 days from receipt of the first level appeal decision, except with respect to urgent care claim appeals as noted below.

**Urgent Care Appeals**

Your appeal may require immediate action if a delay in medical care or treatment could significantly increase the risk to your health, impair the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You, your physician or your authorized representative should call the Plan Administrator as soon as possible.

You will be provided with a determination by telephone, facsimile or other available expeditious method as soon as possible taking into account the medical exigencies, but not later than 72 hours after the plan receives your request for appeal of a claim denial (for medical plans that have only one level of appeal) and no later than 36 hours after the plan receives your request for appeal of a claim denial (for medical plans that have two levels of appeal). For plans that have two levels of appeal, an appeal to the second level of
review will be decided as soon as possible, but not later than 36 hours after the plan receives your request for review of the first level appeal decision. Your second level appeal request for an urgent care claim must be submitted within a reasonable period of time (not to exceed 60 days) after you receive the first level appeal decision.

**External Review for Medical Claims**

For medical benefits, you may have the right to request an external review of a claim involving medical judgment, as determined by the external reviewer, or a coverage rescission. You must request the external review within four months of the date you receive an adverse benefit determination. If your request for an external review is determined eligible for such a review, an independent organization will review the Claims Administrator’s decision and provide you with a written determination, as described in the applicable plan documents.

**Availability of External Review**

External review is not available for all adverse decisions. For example, external review is not available for an adverse decision based on a determination that you fail to meet the requirements for eligibility under the terms of the plan. External review is available only for:

- Any final internal adverse decision (or an initial internal adverse decision on an urgent care claim that qualifies for the expedited external review described below) that involves medical judgment (including, but not limited to, those based on the plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or that a treatment is experimental or investigational; or a determination that the plan is complying with a nonquantitative treatment limitation which generally require parity in the application of medical management techniques), as determined by the external reviewer;
- Any other final adverse decision that involves a rescission of coverage; or
- Any other final adverse decision that is eligible for external review in accordance with applicable guidance (as determined by the plan at the time of the request for external review).

**Request for External Review**

A request for external review must be submitted to the plan no later than four months after you receive notice of an adverse decision for which external review is available.

**Preliminary Review**

Within five business days after the date the plan receives a request for external review, the plan will complete a preliminary review of the request to determine whether:

- You are or were covered under the plan at the time the health care item or service was requested or, for a post-service claim, were covered under the plan at the time the health care item or service was provided;
- The adverse decision does not relate to your failure to meet the requirements for eligibility under the terms of the plan;
- You have exhausted the plan’s internal appeal process (or you are not required to exhaust the internal appeals process under applicable regulations); and
- You have provided all the information and forms required to process an external review.

Within one business day after the plan completes the preliminary review, the plan will issue you a notice in writing. If the request is complete but is not eligible for external review, the notice will describe the reasons...
Referral to Independent Review Organization

External reviews are conducted by independent review organizations (IRO). The plan will assign each external review to an IRO that is accredited by Utilization Review Accreditation Commission (URAC) or a similar nationally-recognized accrediting organization to conduct the external review. The plan will contract with at least three different IROs. The plan will ensure that the IRO process is not biased and ensure the independence of each IRO and will rotate review assignments among them (or the plan will incorporate other independent, unbiased methods for selection of IROs, such as random selection, and will document such methods). No IRO will be eligible for any financial incentives from the plan or the Employer based on the likelihood that the IRO will support the denial of benefits. The IRO process will not impose any costs, including filing fees, on those submitting claims requesting external review.

Under a contract between the plan and the IRO, the IRO that handles external reviews and the plan is required to comply with the following external review requirements:

- The IRO will consult with legal experts where appropriate to make coverage determinations under the plan.
- The IRO will notify you timely in writing of the request’s eligibility and acceptance for external review. This notice will include a statement that you may submit additional information in writing to the IRO within 10 business days following the date you receive the notice. The IRO must consider such additional information in conducting the external review if timely submitted and may, but is not required to accept and consider additional information submitted after 10 business days.
- Within five business days after the date the review is assigned to the IRO, the plan will provide to the IRO the documents and any information considered in making the adverse decision under review. Failure by the plan to timely provide the documents and information must not delay the conduct of the external review. If the plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse decision. Within one business day after making the decision, the IRO must notify you and the plan.
- After receiving any information submitted by you, the IRO must within one business day forward the information to the plan. Upon receipt of any such information, the plan may reconsider its adverse decision that is under review but any reconsideration by the plan will not delay the external review. The external review may be terminated in such cases only if the plan decides to reverse its adverse decision and provide coverage or payment. Within one business day after making such a decision, the plan will provide written notice of its decision to you and the IRO. The IRO must terminate the external review upon receiving the notice from the plan.
- The IRO will review all information and documents timely received. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during the plan’s internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
  - Your medical records;
  - The attending health care professional’s recommendation;
  - Reports from appropriate health care professionals and other documents submitted by the plan, you, or your treating provider;
The terms of the plan, unless the terms are inconsistent with applicable law;

- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

- Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

- The opinion of the IRO’s clinical reviewer after considering the information or documents available to the clinical reviewer that the clinical reviewer considers appropriate.

• The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of final external review decision to you and the plan.

• The IRO’s notice will include:

  - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

  - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

  - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

  - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

  - A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the plan or to you, or to the extent the plan voluntarily makes payment on the claim or otherwise provides benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits;

  - A statement that judicial review may be available to you; and

  - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA.

• The IRO must maintain records of all claims and notices associated with the external review process for six years following the date of its final decision. An IRO must make such records available for examination by you, the plan, or a state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

**Effect of External Review Decision**

An external review decision is binding on the plan, as well as you, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding does not preclude the plan from making payment on the claim or otherwise providing benefits at any time. Upon receiving a notice of a final external review decision reversing an internal adverse decision, the plan will provide any benefits (including by making payment on the claim) pursuant to the final external review...
decision without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

**Expedited External Review**

**Availability of Expedited External Review**

You may make a request for an expedited external review with the plan at the time you receive an adverse decision that otherwise qualifies for external review (as described above) and that is:

- An adverse decision that involves a medical condition for which the time frame for completing an expedited internal appeal under the plan’s normal procedures for urgent care claims would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- A final adverse decision, if you have a medical condition where the timeframe for completing a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse decision concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but has not been discharged from a facility.

**Procedures for Expedited External Review**

The normal procedures for external review (as described above) apply to expedited external review except as otherwise provided in this section.

Immediately upon receipt of a request for expedited external review, the plan must determine whether the request is eligible for standard external review. The plan will immediately send you a notice of its eligibility determination that meets the preliminary review notice requirements described above.

Upon a determination that a request is eligible for expedited external review, the plan will assign an IRO. The plan will provide or transmit all necessary documents and information considered in making the adverse decision that is being reviewed to the IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan’s internal claims and appeals process.

The plan’s contract with the IRO will require the IRO to provide review as expeditiously as your medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO will be required to provide written confirmation of the decision to you and the plan.

**Claims for Disability Benefits**

For claims for disability benefits, the Claims Administrator will notify you of any adverse decision no later than 45 days after the plan receives the claim. This period may be extended by 30 days if it is determined that matters beyond the control of the plan make an extension necessary. You will receive written notice of the extension and the date by which the Claims Administrator expects to decide your claim before the end of the initial 45-day period.
If, before the end of the 30-day period, a decision cannot be made due to matters beyond the control of the plan, the period for making the decision may be extended for up to an additional 30 days. In that case, you will be notified in writing, before the end of the initial 30-day extension period, of the additional extension and the date by which the Claims Administrator expects to decide your claim. Each notice of extension will explain the standards on which entitlement to benefits is based, the reasons for the delay, and any additional information needed for the Claims Administrator to make a decision on the claim.

If the extension is due to your failure to submit information necessary to decide the claim, the time limitations for the Claims Administrator will be tolled from the date the notification of the extension is sent until the date you respond to the request for additional information. You will have 45 days to provide the necessary information.

If Your Disability Claim is Denied

Any adverse decision on a claim for benefits will be provided by the Claims Administrator in a written notice that will include:

- A description of the specific reason or reasons for the denial with reference to any specific plan or insurance contract provisions on which the denial is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary;
- A description of the plan’s appeal procedures and time frames, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse decision on appeal;
- If applicable, a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon and that a copy will be provided free of charge upon request; and
- If the adverse decision was based on a medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision applying the terms of the plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request.

You, your beneficiary or your authorized representative may appeal any denial of a claim for benefits by filing a written request for appeal with the Plan Administrator no later than 180 days after you receive notice of the adverse decision.

If you appeal an adverse disability benefits decision, you have the right to:

- Submit for review, written comments, documents, records and other information relating to the claim;
- Request and be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- A review that takes into account all comments, documents, records and other information submitted by you or your authorized representative, without regard to whether such information was submitted or considered in the initial claim decision;
- A review that does not afford deference to the initial adverse decision and that is not conducted by the individual who made the adverse decision or any subordinate of that person;
- If the appeal involves an adverse decision based on medical judgment, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual; and
• Identification of medical or vocational experts, if any, whose advice was obtained by the plan in connection with the claim review, without regard to whether the advice was relied upon in making the decision.

The decision on review will be made within 45 days after the Claims Administrator receives your request for review, unless special circumstances require an extension of time for processing, in which case, you will receive notice of the extension and a decision will be rendered no later than 90 days after the Claims Administrator receives your request for review.

Upon completion of its review of an adverse initial claim determination, the Claims Administrator will provide to you a written or electronic notice of its decision on review. For any adverse decision on review that notice will include the following:

• A description of the decision;
• A description of the specific reasons for the decision;
• A reference to any relevant plan provision or insurance contract provision on which the decision is based;
• A statement that you are entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the plan’s files which is relevant to your claim for benefits;
• If applicable, a statement describing your right to bring an action for judicial review under ERISA section 502(a);
• If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and
• If the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the plan to your medical circumstances, or a statement that such an explanation will be provided without charge upon request.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>How to File</th>
<th>Where to File</th>
<th>When to File</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical: CareFirst BlueCross BlueShield (BCBS) Medical Plan (Both Plans)</strong></td>
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<tr>
<td><strong>Major Medical Claims</strong></td>
<td>Complete a CareFirst BCBS Major Medical Claim Form.</td>
<td>Mail your completed form and all required documentation to CareFirst at the address on the form.</td>
<td>Complete this form as soon as possible. Claims that are filed more than 12 months from date of service will not be paid.</td>
</tr>
<tr>
<td><strong>Prescription Reimbursement</strong></td>
<td>Visit <a href="http://www.express-scripts.com">www.express-scripts.com</a> for online filing.</td>
<td>File online at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or submit paper claims through the address listed on the Express Scripts reimbursement form.</td>
<td>Reimbursement claims should be filed promptly.</td>
</tr>
<tr>
<td>Benefit</td>
<td>How to File</td>
<td>Where to File</td>
<td>When to File</td>
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<tr>
<td>Prescription Mail-Order</td>
<td>Visit <a href="http://www.express-scripts.com">www.express-scripts.com</a> for online filing.</td>
<td>File online at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or submit paper claims through the address listed on the Express Scripts reimbursement form.</td>
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<tr>
<td>Medical: EHP Classic Plan</td>
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<tr>
<td>Medical Claims</td>
<td>Complete a Medical Claim Form.</td>
<td>Mail your completed form and all required documentation to EHP at the address on the form.</td>
<td>Claims should be reported promptly. No claims will be accepted after one year from the date services or supplies were provided.</td>
</tr>
<tr>
<td>Prescription Reimbursement</td>
<td>Visit <a href="http://www.express-scripts.com">www.express-scripts.com</a> for online filing.</td>
<td>File online at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or submit paper claims through the address listed on the Express Scripts reimbursement form.</td>
<td>Reimbursement claims should be filed promptly.</td>
</tr>
<tr>
<td>Prescription Mail-Order</td>
<td>Visit <a href="http://www.express-scripts.com">www.express-scripts.com</a> for online filing.</td>
<td>File online at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or submit paper claims through the address listed on the Express Scripts reimbursement form.</td>
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<tr>
<td>Medical: BlueChoice</td>
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<td></td>
<td>No claim forms are required.</td>
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<tr>
<td>Medical: Kaiser Permanente (Emergency care from a non-Kaiser provider)</td>
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<tr>
<td>Benefit</td>
<td>How to File</td>
<td>Where to File</td>
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<tr>
<td>No claim forms are required.</td>
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<tr>
<td><strong>Dental: CareFirst BlueCross BlueShield (BCBS) Dental Plan</strong></td>
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<tr>
<td><strong>Dental Claims</strong></td>
<td>Complete a CareFirst Dental Claim Form.</td>
<td>Mail your completed form and all required documentation to CareFirst at the address on the form.</td>
<td>File your claim as soon as possible after the dental service has been performed. Claims that are filed more than 12 months from the date of service will not be paid.</td>
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<tr>
<td><strong>Dental: CIGNA</strong></td>
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<tr>
<td>Dental Claims</td>
<td>Complete a CIGNA Dental Claim Form.</td>
<td>Mail your completed form and all required documentation to CIGNA at the address on the form.</td>
<td>File your claim as soon as possible after the dental service has been performed.</td>
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<tr>
<td><strong>Dental: United Concordia ConcordiaPLUS Dental Plan</strong></td>
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<tr>
<td>No claim forms are required.</td>
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<tr>
<td><strong>FSA: Health Care Flexible Spending Account</strong></td>
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<tr>
<td><strong>Health Care Payment</strong></td>
<td>If you use your health care card, you pay for services on the spot directly from your Health Care FSA; in some cases, you may be asked later to submit a photocopy of your receipt (for verification purposes).</td>
<td>Submit missing receipts or payments to WageWorks by completing the Card Use Verification Form included in your monthly statements or by uploading your required documentation online.</td>
<td>Payment for service using your health care card does not require you to file any claims. You may access your account online or by phone. Your account statement details your last month’s account activity and may also include items that require your immediate attention or action.</td>
</tr>
<tr>
<td>Benefit</td>
<td>How to File</td>
<td>Where to File</td>
<td>When to File</td>
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<tr>
<td>Health Care Payment: Reimbursement Request</td>
<td>Complete a Health Care Pay Me Back Claim Form.</td>
<td>Mail your completed form and required documentation to WageWorks at the address on the form, fax it to the number provided on the form, or enter your claim online and upload your required documentation.</td>
<td>Reimbursements are generally processed immediately, with a check mailed to your home or direct deposit made to your checking or savings account. You may be reimbursed up to the amount you elected to contribute for the year (less the amount already reimbursed). You have until April 30 of the following year to file claims for expenses incurred prior to December 31.</td>
</tr>
<tr>
<td>Health Care Direct Payment to Provider</td>
<td>Use the Pay-My-Provider feature for those health care providers you visit on a regular basis.</td>
<td>Complete the online Pay My Provider Payment Form at the WageWorks website, <a href="http://www.wageworks.com">www.wageworks.com</a></td>
<td>Complete the form prior to the receipt of any services.</td>
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<tr>
<td>FSA: Dependent Care</td>
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<tr>
<td>Dependent Care Payment: Reimbursement Request</td>
<td>Complete a Dependent Care Pay Me Back Claim Form.</td>
<td>Mail your completed form and required documentation to WageWorks at the address on the form, fax it to the number provided on the form.</td>
<td>Reimbursements are generally processed immediately, with a check mailed to your home or direct deposit made to your checking or savings account. You may be reimbursed up to the amount you have contributed (less the amount already reimbursed). You have until April 30 of the following year to file claims for expenses incurred prior to December 31.</td>
</tr>
<tr>
<td>Dependent Care Direct Payment to Provider</td>
<td>Use the Pay-My-Provider feature to make payment directly to your dependent care provider.</td>
<td>Complete the online Pay My Provider Payment Form at the WageWorks website, <a href="http://www.wageworks.com">www.wageworks.com</a></td>
<td>Complete the form prior to the receipt of any services.</td>
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<td>Life, AD&amp;D, and Business Travel Accident Insurance Plans</td>
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<tr>
<td>Benefit</td>
<td>How to File</td>
<td>Where to File</td>
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<tr>
<td>Life, AD&amp;D, and Business Travel Accident Insurance Plans</td>
<td>You or your beneficiary should contact the Benefits Service Center.</td>
<td>Provide all requested information to the Benefits Service Center.</td>
<td>Your claims should be filed as soon as possible after a covered loss (generally within 90 days). In all cases, however, claims must be filed within one year of the date of a covered loss.</td>
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<tr>
<td>• Basic Life Insurance</td>
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<td>• Supplemental Life Insurance</td>
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<td>• Dependent Life Insurance</td>
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<tr>
<td>• Accidental Death and Dismemberment</td>
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<tr>
<td>• Business Travel Accident Insurance</td>
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<tr>
<td>Disability Protection</td>
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<tr>
<td>Short-Term Disability</td>
<td>If your absence due to an illness or injury exceeds 14 consecutive days, notify your supervisor.</td>
<td>Call The Hartford at 800-303-9744, Monday through Friday, 8 a.m. to 8 p.m. The Hartford will take all the necessary information to file your claim and will make sure you understand key elements of your disability plan, such as how long you must be disabled before your benefits begin and any factors that might limit benefit payment.</td>
<td>As soon as possible after an illness or injury that prevents you from working, but no later than your 10th day of absence.</td>
</tr>
<tr>
<td>Long-Term Disability</td>
<td>Complete a Long-Term Disability Form.</td>
<td>Mail your completed form and required documentation to The Hartford at the address on the form, or fax it to the number provided on the form.</td>
<td>The LTD insurance carrier will contact you once it appears that your absence from work due to disability will extend beyond 180 days.</td>
</tr>
</tbody>
</table>
All Other Plans: Claims for Benefits, Denials and Appeals

In most cases, to receive or apply for benefits, you or your authorized representative should contact the Benefits Service Center.

For any claim that is not a health claim or a disability claim, you will be notified within 90 days after your claim is filed whether the claim is allowed or denied, unless circumstances require an extension of the time for decision. In that case, the Claims Administrator will provide written notice of the need for an extension before the end of the 90-day period. If an extension applies, you will be notified of the Claims Administrator’s decision within 180 days after your claim is filed.

If Your Claim is Denied

If all or part of your claim for benefits is denied, you will receive written or electronic notice of the adverse decision, which will include:

- A description of the specific reason or reasons for denial with reference to any specific plan or insurance contract provisions on which the denial is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary; and
- A description of the plan’s appeal procedures and time frames, including, if applicable, a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse decision on appeal.

Following any adverse decision on your initial claim, including any denial based on your eligibility to participate in the plan, you may request an appeal. To request an appeal, you must follow the appeal procedures outlined below:

- Within 60 days after you receive notice of an adverse decision, you or your authorized representative must submit a written request for reconsideration of your claim to the Claims Administrator (for some benefits, the Insurer or claims processor may provide a longer period for filing an appeal as described in separate benefits booklets).
- You have the right to submit for review, written comments, documents, records and other information relating to the claim for benefits.
- You have the right to request and be provided, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim.
- In addition, for appeals of claims for retirement plan benefits, you have the right to request a hearing.

The Claims Administrator’s review will take into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim decision.

You can help your appeal by clearly explaining why you think the adverse decision was incorrect. Also, whenever possible, send copies of any documents or records that support your appeal. Whether or not you can provide such additional information, your application will be thoroughly reconsidered after your appeal is received.

Within a reasonable period of time, but not later than 60 days after the Claims Administrator receives your request for review, the Claims Administrator will review and answer your request electronically or in writing. If the decision will take longer than 60 days, you will be notified, before the end of the initial 60-day period, of the delay and given the reason more time is needed and the date by which the plan expects to make a decision. The extension may not exceed 60 days.
The Claims Administrator’s decision on appeal will be final and binding on all parties, unless a court later overrides that decision. Any notice of an adverse decision on appeal will include:

- The specific reason or reasons for denial with reference to any plan provisions or insurance contract provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information in the plan’s files that is relevant to your claim; and
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures, and, if applicable, a statement of your right to bring an action under section 502(a) of ERISA.

**Additional Rules for All Claims**

**Claim Forms**

In most cases, to receive or apply for benefits, you or your designated beneficiary must file a written claim using the appropriate forms. Unless noted otherwise, most forms referenced below are available from JHU’s benefits website at [http://benefits.jhu.edu/resources/forms.cfm](http://benefits.jhu.edu/resources/forms.cfm). You may also contact the Benefits Service Center.

**Calculation of Time Periods**

For purposes of the time periods specified in this “Claims Procedures” section, the period during which a benefit determination must be made begins when a claim or appeal is filed in accordance with the plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because you fail to submit all information necessary for an initial claim for health benefits (other than urgent care benefits) or for disability benefits, the period for making the determination will be “frozen” from the date the notice requesting additional information is sent to you until the day you respond. Also, if a time period is extended because you fail to submit all information necessary for an appeal of an adverse decision for benefits other than health benefits, the period for making the determination on appeal will be “frozen” from the date the notice requesting additional information is sent to you until the day you respond.

**You Must Follow the Plan’s Claims Procedures**

You must follow the claims procedures described above to be entitled to file any legal action (or to request an external review) for benefits under the plan (unless the plan fails to follow those procedures).

**Plan’s Failure to Follow Procedures**

If the plan fails to substantially follow the claims procedures described above, you will be deemed to have exhausted the administrative remedies available under the plan and will be entitled to pursue any available remedy under ERISA on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

For any claim for benefits under coverage that is subject to the Affordable Care Act, you are deemed to have exhausted the plan’s internal claims and appeals process if the plan fails to strictly adhere to the applicable requirements of the U.S. Department of Labor’s claims procedure regulations, except for certain minor violations. For this purpose, the plan’s failure to comply with the claims procedure regulations is considered a minor violation if (i) the violation does not cause, and is not likely to cause, prejudice or harm to you, (ii) the violation was for good cause or due to matters beyond the control of the plan, (iii) the violation occurred as part of an ongoing, good faith exchange of information between the plan and you and (iv) the violation is
not part of a pattern or practice of violations by the plan. If an issue arises regarding whether this “minor violation” exception applies, you may request a written explanation of the violation from the plan and the plan will provide the explanation within 10 days, including a specific description of its reasons, if any, for asserting that the violation should not cause the plan’s internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that the plan met the standards for the minor violation exception, you will be permitted to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin to run when you receive the notice.

In cases where you are deemed to have exhausted the plan’s internal claim procedures, you have the right to pursue any available remedy under ERISA and, if the claim involves coverage that is subject to the Affordable Care Act, you may have the right to pursue any remedy under any available external review process provided under federal or state law in accordance with the Affordable Care Act.

Statute of Limitations for Plan Claims

Please note: No legal action may be commenced or maintained to recover benefits under the plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Insured Benefits and State Law

For any insured benefit under this plan, nothing in the plan’s claims procedures will be construed to supersede any provision of any applicable state law that regulates insurance, except to the extent that such law prevents application of the plan’s claims procedures.

For Other Information, Go To...

<table>
<thead>
<tr>
<th>The Big Picture</th>
<th>For general information about JHU’s overall benefits program and how the myChoices Program works</th>
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<td>Changes to Your Benefits</td>
<td>For information on how changes in family or work situations may affect your coverage</td>
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<tr>
<td>Medical, Dental, Life, Personal Accident, and Business Travel Accident Insurance, Disability, Flexible Spending Accounts</td>
<td>For descriptions of your benefits</td>
</tr>
<tr>
<td>Resources</td>
<td>For a list of contacts and available resources</td>
</tr>
</tbody>
</table>
Chapter 11 – Resources

For information about the benefits available to you, contact the Benefits Service Center via email at benefits@jhu.edu, or call 410-516-2000. Office hours are Monday through Friday, 8:30 am - 5:00 pm.

Johns Hopkins University at Eastern
Benefits Service Center
1101 East 33rd Street, Suite D200
Baltimore, MD 21218
Fax: 443-997-5820

Listed below are resources for additional information about JHU’s benefits, policies, and programs.

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<tr>
<th>Benefit Plan Contact</th>
<th>Phone Number</th>
<th>Call For...</th>
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<tr>
<td><strong>Medical</strong></td>
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<tr>
<td>CareFirst BlueCross BlueShield</td>
<td>877-691-5856</td>
<td>General customer service.</td>
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<tr>
<td><a href="http://www.carefirst.com">www.carefirst.com</a></td>
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<tr>
<td>EHP (faculty and staff only)</td>
<td>800-261-2393 or 410-424-4450</td>
<td>General customer service.</td>
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<tr>
<td><a href="http://www.ehp.org">www.ehp.org</a></td>
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<tr>
<td>BlueChoice</td>
<td>877-691-5856</td>
<td>General customer service.</td>
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<tr>
<td><a href="http://www.carefirst.com">www.carefirst.com</a></td>
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<tr>
<td>Kaiser Permanente</td>
<td>800-777-7902</td>
<td>General customer service (medical and prescription drug).</td>
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<td><a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a></td>
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<td>Express Scripts</td>
<td>800-336-3862</td>
<td>• General customer service&lt;br&gt;• Check formulary list for your drug&lt;br&gt;• Find out more about mail order prescriptions</td>
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<tr>
<td><a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
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<tr>
<td><strong>Dental</strong></td>
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<tr>
<td>CareFirst BlueCross BlueShield</td>
<td>888-755-2657</td>
<td>• General customer service&lt;br&gt;• Find an in-network dentist</td>
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<tr>
<td><a href="http://www.carefirst.com">www.carefirst.com</a></td>
<td></td>
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<tr>
<td>CIGNA</td>
<td>888-336-8258</td>
<td>• General customer service&lt;br&gt;• Find an in-network dentist</td>
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<tr>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
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<tr>
<td>Benefit Plan Contact</td>
<td>Phone Number</td>
<td>Call For...</td>
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<tr>
<td>Dental (cont’d)</td>
<td>866-357-3304</td>
<td>For more information before Enrollment.</td>
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</table>
| United Concordia PLUS                      | 800-332-0366       | • General customer service  
• To find an in-network dentist  
• Claims service               |
| www.ucci.com                               |                    |                                                                             |
| Flexible Spending Accounts                  |                    |                                                                             |
| WageWorks                                  | 877-924-3967       | • General customer service  
• Claims service                  |
| www.wageworks.com                          |                    |                                                                             |
| Life Insurance                             |                    |                                                                             |
| Securian Financial Group                    | 866-293-6047       | General customer service                                                   |
| www.securian.com                           |                    |                                                                             |
| Benefits Service Center                     | 410-516-2000       | Information in the event of a claim.                                       |
| www.benefits.jhu.edu                       |                    |                                                                             |
| Voluntary Vision                            |                    |                                                                             |
| United Healthcare                          | 855-523-9355       | General customer service                                                   |
| www.hihealthinnovations.com                | 866-795-9362       | Enrollment                                                                  |
| Voluntary Vision                            |                    |                                                                             |
| AD&D (faculty and staff only)              |                    |                                                                             |
| Securian Financial Group                    | 866-293-6047       | • General customer service  
• Emergency assistance in the United States  
• Emergency assistance while overseas |
<p>| <a href="http://www.securian.com">www.securian.com</a>                           |                    |                                                                             |
| Benefits Service Center                     | 410-516-2000       | Information in the event of a claim.                                       |
| <a href="http://www.benefits.jhu.edu">www.benefits.jhu.edu</a>                       |                    |                                                                             |
| Dependent Life Insurance                    |                    |                                                                             |
| Securian                                    | 866-293-6047       | General customer service                                                   |
| <a href="http://www.securian.com">www.securian.com</a>                           |                    |                                                                             |
| Benefits Service Center                     | 410-516-2000       | Information in the event of a claim.                                       |</p>
<table>
<thead>
<tr>
<th>Benefit Plan Contact</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td><strong>Accident Insurance</strong></td>
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<tr>
<td>MetLife</td>
<td>866-795-9362</td>
<td>General customer service.</td>
</tr>
<tr>
<td><a href="http://www.jhuvoluntarybenefits.com">www.jhuvoluntarybenefits.com</a></td>
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<tr>
<td><strong>Critical Illness Insurance</strong></td>
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<tr>
<td>MetLife</td>
<td>866-795-9362</td>
<td>General customer service.</td>
</tr>
<tr>
<td><a href="http://www.jhuvoluntarybenefits.com">www.jhuvoluntarybenefits.com</a></td>
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<tr>
<td><strong>Group Travel Insurance</strong></td>
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<tr>
<td>The Hartford</td>
<td>800-243-6108</td>
<td>General customer service.</td>
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<tr>
<td><a href="http://www.thehartford.com">www.thehartford.com</a></td>
<td></td>
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<tr>
<td><strong>Family Leave &amp; Disability</strong></td>
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<tr>
<td>The Hartford</td>
<td>800-303-9744</td>
<td>General customer service.</td>
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<td><a href="http://www.thehartford.com">www.thehartford.com</a></td>
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<tr>
<td><strong>Wellness Program</strong></td>
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<tr>
<td>Healthy at Hopkins</td>
<td>410-516-2000</td>
<td>Information about wellness programs offered by JHU.</td>
</tr>
<tr>
<td><a href="http://benefits.jhu.edu/wellness/">http://benefits.jhu.edu/wellness/</a></td>
<td></td>
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<tr>
<td>Office of Occupational Health Services</td>
<td>410-516-0450</td>
<td>Information about wellness programs offered by JHU.</td>
</tr>
<tr>
<td>Office of Work, Life and Engagement</td>
<td>443-997-7000</td>
<td>More information about WorkLife programs.</td>
</tr>
<tr>
<td><a href="http://www.hopkinsworklife.org">www.hopkinsworklife.org</a></td>
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<tr>
<td><strong>Faculty and Staff Assistance Plan</strong></td>
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<tr>
<td>FASAP</td>
<td>443-997-7000</td>
<td>Assistance with personal problems, family issues, etc.</td>
</tr>
<tr>
<td><a href="http://hopkinsworklife.org/fasap/">http://hopkinsworklife.org/fasap/</a></td>
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<tr>
<td><strong>COBRA</strong></td>
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</tbody>
</table>
| Wageworks (COBRA Administration and Billing)             | 877-722-2667 or 877-266-3947 | - Assistance with COBRA questions  
- General customer service |
| [https://employerbenefits.wageworks.com/](https://employerbenefits.wageworks.com/) |               |                                                  |
| Benefits Service Center                                   | 410-516-2000  | - Assistance with COBRA questions  
- General customer service |
<p>| <a href="http://www.benefits.jhu.edu">www.benefits.jhu.edu</a>     |               |                                                  |</p>
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<td><strong>JHU Benefits Services and Operations</strong></td>
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<tr>
<td>Wageworks(Retiree, LTD and Special Billing)</td>
<td>877-722-2667 or 877-266-3947</td>
<td>General customer service for retiree health insurance, LTD and special billing.</td>
</tr>
<tr>
<td><a href="https://employerbenefits.wageworks.com/">https://employerbenefits.wageworks.com/</a></td>
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<tr>
<td>Benefits Service Center</td>
<td>410-516-2000</td>
<td>General assistance with Benefits.</td>
</tr>
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<td><a href="http://www.benefits.jhu.edu">www.benefits.jhu.edu</a></td>
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<tr>
<td><strong>Government Entities</strong></td>
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<tr>
<td>Internal Revenue Service</td>
<td>800-829-1040</td>
<td>Assistance with tax-related questions.</td>
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<tr>
<td><a href="http://www.irs.gov">www.irs.gov</a></td>
<td></td>
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<tr>
<td>Social Security Administration</td>
<td>800-772-1213</td>
<td>Assistance with questions about Social Security benefits and programs.</td>
</tr>
<tr>
<td><a href="http://www.ssa.gov">www.ssa.gov</a></td>
<td></td>
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<tr>
<td>Administration on Aging</td>
<td>202-619-0724</td>
<td>Assistance with topics, programs, and services related to aging.</td>
</tr>
<tr>
<td><a href="http://www.aoa.gov">www.aoa.gov</a></td>
<td></td>
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<tr>
<td>Agency for Healthcare Research and Quality</td>
<td>888-512-6090</td>
<td>Access to health care decision-making and research tools.</td>
</tr>
<tr>
<td><a href="http://www.qualityindicators.ahrq.gov">www.qualityindicators.ahrq.gov</a></td>
<td></td>
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