Chapter 3 – Medical Benefits

Fast Facts
- You have three options for medical coverage.
- All medical options cover prescription drugs.
- You may decline medical coverage if you are covered under another plan.
- You have several levels of coverage to choose from: individual, parent/child, two adults or family coverage.

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. You 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).

Note: BlueChoice HMO is closed to new participants effective January 1, 2010. Information on this closed plan begins on page 3.50.

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</th>
<th>Point-of-Service Plan</th>
<th>Health Maintenance Organization (HMO)</th>
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<tbody>
<tr>
<td></td>
<td>CareFirst BlueCross BlueShield Medical Plan</td>
<td>EHP Classic</td>
<td>Kaiser Permanente</td>
</tr>
<tr>
<td>Choice of provider</td>
<td>You see any provider; you pay less when you use network providers</td>
<td>You see any provider; you 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 reasonable charges (after you meet a deductible) for covered services each time you need care</td>
<td>Your cost will vary based on how you seek care. Some covered services may require copays, some coinsurance (20% in-network, 30% out-of-network after the deductible)</td>
<td>No deductible; you pay a copay, and then the plan pays the balance for covered services</td>
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</table>

The Johns Hopkins University believes all medical benefits under this plan are “grandfathered” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act,
a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from a grandfathered health plan status can be directed to the Benefits Service Center at 410-516-2000 or e-mail at benefits@jhu.edu. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Eligibility
Eligibility for the Medical plan is outlined in “The Big Picture,” the first chapter of this document.

Cost
Your cost for coverage depends on the medical option and level of coverage that 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 the university’s myChoices Program.

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

*Note: Per IRS regulations, the value of benefits for same-sex domestic partners and their child(ren) is taxable to the employee; however, if a same-sex domestic partner and his/her child(ren) are qualified tax dependents of the employee under the IRS regulations, then the value is not taxable to the employee.*

Your Medical Plan Options
The Johns Hopkins University group health plan offers three medical options, so you can choose the one that best meets your needs. Each option offers a different level of coverage for preventive care and 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 Plan—This plan provides traditional indemnity-type medical coverage. You pay less for care when you use a JHU network provider; 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 reasonable charges 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—This plan is a point-of-service plan, which provides broad medical coverage and the flexibility to use any provider. You 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%, with no 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—This plan is a health maintenance organization (HMO), which provides broad medical coverage that must be coordinated and approved by your HMO’s primary care physician. 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.

Specific coverage information (deductible amounts, copay requirements, etc.) for all three plans can be found in the Chapter 4, “Medical Benefits Summary.”

Declining Medical Coverage
You may decline medical coverage if you have coverage under another group medical plan (such as coverage through your spouse’s or same-sex 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 the university and later lose the coverage you have elsewhere, you have 30 days to enroll in the university's group health plan. You can enroll in the plan by making an election under the university's myChoices Program. Read more information on making an election under “Qualifying Events” in Chapter 1, “The Big Picture.”

Your Spending Account
You can use your Health Care Spending 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
- Not be provided solely for personal comfort or convenience

The exact definition of “medical necessity” is determined by the insurance carrier, 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 or 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. 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.

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 should not base this determination on whether the Plan will or will not provide coverage for that care. For further information about coverage, see “Emergency Services” under each medical plan option'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 insurance carrier, your HMO, or EHP within 48 hours of the admission.

Prescription Drug Benefits

Medco

Medco will administer prescription drug benefits for the CareFirst BlueCross BlueShield, and EHP Classic Medical Plan options.

Subject to all of the applicable limitation and provisions of the plan, 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.

• 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.

• 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.

When you purchase your medication, the amount of your copayment will depend on which tier your drug falls under. You may purchase your prescriptions either through a retail pharmacy or through the mail-order program.

• Retail. You will receive up to a 30-day supply of your medication when you purchase it through a participating retail pharmacy. Take your Medco ID card to the pharmacy where you normally order your prescriptions; the pharmacy will fill your prescription for up to a 30-day supply of the prescribed medication.

• 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 for the cost of two 30-day supplies. In addition, with the mail-order program, you have the convenience of direct delivery to your home. Go to www.medco.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 Web site, please take a moment to register; have your member ID and a prescription number available.) You may also call 1-800-336-3862.

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

To make sure your prescription is on the formulary list, go to www.medco.com or call 1-800-336-3862.

Specific coverage information can be found in Chapter 4, “Medical Benefits Summary.”

Kaiser Permanente

Kaiser Permanente will administer 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 34-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: 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 1-800-733-6345. You can speak to pharmacy mail order customer service representative who can help explain the mail program and get a prescription transferred from a pharmacy to Kaiser’s Mail Order Program.
    - Call EZ Refill at 1-800-700-1479 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 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 and order refills.

• When you purchase your medication, the amount of your copayment will depend on whether your prescription is generic or brand, 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.

Specific coverage information can be found in Chapter 4, “Medical Benefits Summary.”
Notice of Privacy Practices
The health plan options offered under the Plan 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 Summary 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.

Certificates of Group Health Coverage
Under a federal law known as HIPAA, the Plan is required to provide a “Certificate of Group Health Plan Coverage” (also known as a “Certificate of Creditable Coverage”) upon request from any person who is currently covered under the Plan’s medical coverage or who had medical coverage under the Plan within the previous 24 months. A current or former participant may request a Certificate of Group Health Plan Coverage by writing, visiting or calling the Plan Administrator at the address or phone number provided later in this Summary.

A Certificate of Group Health Coverage is evidence of coverage under this plan. Under HIPAA, an individual may need evidence of coverage to reduce a preexisting condition exclusion period under another plan, to help get special enrollment in another plan, or to get certain types of individual health coverage even if he or she has health problems.

If an eligible individual requests a certificate from the Plan, the Plan will mail the certificate to the person requesting it, by first class mail, within seven business days after receiving a request. If an individual requests that a certificate be sent to another person or entity, such as another employer’s plan, the Plan will mail the certificate to the designated recipient, within the same time period.

If a Certificate of Group Health Coverage applies to more than one person and the coverage information is identical for each person, one certificate may be provided for all individuals for whom a certificate was requested, as long as they all reside at the same address (according to information provided to the Plan Administrator). Separate certificates will be provided to an individual if the information regarding that individual is not identical or if he or she resides at a different address.

The Certificate of Group Health Coverage requirements apply only to the Plan’s medical coverage. If you have any questions about your coverage under any of the Plan’s other benefits, you may also contact the Plan Administrator for help, but the Plan is not required to provide a certificate of coverage.

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 also 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 is receiving benefits under the plan in connection with a mastectomy and the patient elects 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 will be subject to the applicable deductibles and coinsurance provisions like other medical and surgical benefits covered under the plan.

Description of the Indemnity Plan: CareFirst BlueCross BlueShield Medical Plan
CareFirst offers traditional indemnity-type medical coverage. You pay less for care when you use a provider in an approved network. If you use a JHU network provider, for most covered services, the coverage is 100% after you meet a deductible. If you use a provider who is not a JHU network provider, your coverage is 80% of the allowable charges for most covered services, after you meet a deductible.

Please note that 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 JHU network provider 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—you are paying 20% of a “discounted” charge.

Specific coverage information (deducible amounts, copay requirements, etc.) can be found throughout this chapter and in Chapter 4, “Medical Benefits Summary.”
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 will require less payment from you than those in the CareFirst BCBS PPO Network (sometimes there is no payment at all).
- The plan pays benefits after you pay your annual deductible. You will pay a percentage of allowed charges for covered services.
- When your share of covered expenses in a calendar year (excluding your deductible) 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 Charges

An allowed charge is the maximum the medical option will pay for a covered service. Under the CareFirst BlueCross BlueShield Medical Plan, for physician and non-facility services, the allowed charge is the amount BlueCross BlueShield had agreed to pay to providers who contract with CareFirst 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 CareFirst.

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 CareFirst has set as an allowed charge. For example, let’s say you saw a specialist for inpatient care. If we assume your deductible has already been met, your plan will pay for 80% of the allowed charge for your visit; you will be responsible for the 20% of the allowed charge of your visit. Your provider charged you $250 for the visit, but the allowed charge set by CareFirst is $200. You will be responsible for a total charge of $90:

| A. Charge by specialist | $250 |
| B. Allowed charge for comparable service | $200 |
| C. Your portion (20%) of allowed charge | $40 |
| D. Balance billing (amount charged by specialist over the allowed charge, or $250 minus $200) | $50 |
| E. Your total cost: your portion of allowed charge plus balance billing (line C. plus line D.) | $90 |

Your Deductible

You and each individual covered through you must pay an amount each calendar year before the plan begins to pay benefits for covered services. This amount is called the deductible. Once you reach your annual deductible, the plan pays a percentage of the reasonable charges, subject to option limits, for your remaining covered expenses in that year. A new deductible applies each calendar year. Any 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 plan are as follows:

<table>
<thead>
<tr>
<th>Annual Deductible</th>
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<tbody>
<tr>
<td>Per individual</td>
<td>$250</td>
</tr>
<tr>
<td>Per two adults</td>
<td>$500</td>
</tr>
<tr>
<td>Per parent/child</td>
<td>$500</td>
</tr>
<tr>
<td>Per family</td>
<td>$750</td>
</tr>
</tbody>
</table>

The deductible does not apply to some services (e.g., physical exams) and is waived in other situations.

**Understanding the Family Deductible Limit**
If you enroll for coverage for you and your spouse, 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 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 allowed charges
- Above the coverage limit
- For any uncovered expenses
- As copayment for inpatient admission, which carries a separate $250 copay per 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, excluding your deductible. 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 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:

<table>
<thead>
<tr>
<th>Annual out-of-pocket maximum</th>
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<tbody>
<tr>
<td>Per individual</td>
<td>$1,500</td>
</tr>
<tr>
<td>Per two adults</td>
<td>$3,000</td>
</tr>
<tr>
<td>Per parent/child</td>
<td>$3,000</td>
</tr>
<tr>
<td>Per family</td>
<td>$4,500</td>
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</tbody>
</table>

**Understanding the Family Out-of-Pocket Maximum**
If you enroll for coverage for you and your spouse, 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 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 family amount, up to allowed charges, whether or not you or any dependent reach the individual amount. You pay any amounts in excess of the allowed charges.
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:

- Toward your deductible
- Above reasonable and customary charges
- Above any plan limit
- For any uncovered expenses
- As copayment for inpatient admission, which carries a separate $250 copay per inpatient admission

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. The absence of immediate medical attention for these symptoms could reasonably be expected 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
- In the case of 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.

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 CareFirst within 48 hours of the admission.

What’s Covered by the CareFirst BlueCross BlueShield Medical Plan

<table>
<thead>
<tr>
<th>Annual deductible</th>
<th>$250 per person/$750 per family (not counting certain charges as discussed above)</th>
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</thead>
<tbody>
<tr>
<td>Annual out-of-pocket maximum</td>
<td>$1,500 per person $4,500 per family (not including deductible and certain charges as discussed above)</td>
</tr>
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Specific coverage information (deductible amounts, copay requirements, etc.) can be found in Chapter 4, “Medical Benefits Summary.”

Preventive Services
Subject to all of the applicable limitations and provisions of the plan, services for preventive care are generally covered at 100%. These services include:

- Periodic 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; deductible waived; unlimited visits

Physician and Provider Services
Subject to all of the applicable limitations and provisions of the plan, physician services are generally covered at 80% (100% covered after the deductible if the service is provided by a JHU network provider). These services include:

• Office visit
• Medical and surgical services
• Specialist care (inpatient)
• Second surgical opinion (no deductible)
• Diagnostic services (outpatient)

Physician services provided in an outpatient hospital facility are covered at 100% of allowed benefit, no deductible.

Hospital Services
Subject to all of the applicable limitations and provisions of the plan, hospital services are generally covered at 80% after deductible and $250 hospital copay. 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 plan area) for a medical emergency, trauma or accident and emergency care follow up visits (a $75 facility copay is required; the facility copay is waived if admitted)
• Emergency care (out of plan area—life threatening or serious emergencies) for medical emergency, trauma or accident and emergency care follow up visits (a $75 facility copay is required; the facility copay is waived if admitted)
• 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, 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, serious dysfunction of any organ or place patient’s health in serious jeopardy.

(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 Drug Abuse Administration of the Maryland State of Health and Mental Hygiene. Subject to all of the applicable limitations and provisions of the plan, covered services for mental health and substance abuse include:

• Mental and nervous (inpatient) 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) provided in an 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 Drug Abuse Administration of the Maryland State of Health and Mental Hygiene as a Residential Drug Free Treatment Rehabilitation Program
- 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, outpatient drug abuse counseling programs (crisis intervention programs and hotlines are not included)

For additional information about covered services, see Chapter 4, “Medical Benefits Summary.”

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 of the applicable limitations and provisions of the plan, following is a list of other services covered by the plan:

- Reproductive health (see Chapter 4, “Medical Benefits Summary,” for specific information about covered services), including:
  - Pre- and post-natal care
  - Family planning and fertility testing
  - Artificial insemination (requires authorization by the plan)
  - In vitro fertilization (requires authorization by the plan)

- Hearing exams and hearing aids for minor dependent children (covered at 100% of allowed benefit up to $1400 every 36 months for one hearing aid for each hearing impaired ear)
- Physician-administered injectibles (self-injectibles are covered under the prescription plan)
- Prescription drugs (drugs, biologicals and compounded prescriptions prescribed by a health care practitioner and pre-approved by CareFirst on an exception basis)

The features of the medical benefits offered under the plan are also summarized in a matrix found in Chapter 4, “Medical Benefits Summary.” If there are any discrepancies between the information in this document and the Plan document, the Plan document will govern.

What’s Not Covered
CareFirst 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
- 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 Evidence of Coverage 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. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.

- Cosmetic services (except for Mastectomy—Related Services and services for cleft lip or cleft palate or both).

- 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 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 stated in the Description of Covered Services.

- Any procedure or treatment designed to alter an individual’s physical characteristics to those of the opposite sex.

- Lifestyle improvements, including, but not limited to smoking cessation, health education classes and self-help programs except as stated in the Description of Covered Services.

- 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. These services may be
covered under a separate rider purchased by the Group and attached to the Evidence of Coverage

• 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
  - Administrative fees charges 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 this 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 for by them

• Services that are non-medical in nature, including, but not limited to personal hygiene, cosmetic and convenience items, including, but not limited to, 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 mental retardation 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 except as stated in the Description of Covered Services, Diabetes Equipment, Supplies, and Self-Management Training

• Tinnitus maskers, purchase, examination, or fitting of Hearing Aids except as stated in the Description of
Covered Services, Hearing Aids. Hearing care benefits for an adult Member may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage

- Services related to human reproduction other than specifically described in this Evidence of Coverage 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
- Routine or periodic physical or gynecological (GYN) exams or diagnostic services related to them unless otherwise stated
- 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. Exclusions to these laws exist for partnerships, sole proprietorships and officers of closed corporations. If a Member is exempt from the above laws, the benefits of this Evidence of Coverage will be provided for Covered Services
- 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
- Hearing care except as otherwise stated

**Description of the Point-of-Service Plan: EHP Classic**

Johns Hopkins Employer Health Programs (EHP) offer 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 extended its provider network through MultiPlan to cover all 50 states. MultiPlan's PHCS Healthy Directions offers a national network of doctors, hospitals and ancillary providers. 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.

In an Emergency
In case of emergency (as defined earlier in this chapter), get help immediately. If you’re admitted to the hospital, you (or someone on your behalf) must notify Johns Hopkins EHP at (410) 424-4450 or 1-800-261-2393 within 48 hours after the admission.

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.  
|            | • Most services are covered at 80%, and you pay the remaining 20% until you reach your annual out-of-pocket maximum  
|            | • Some services are only available 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.  
|             | • Preventative care (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 of $250 per person ($750 per family). 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.

GO TO HEALTH & WELFARE HANDBOOK

CONTACT BENEFITS

3.16

Medical Benefits
Specific coverage information (deductible amounts, copay requirements, etc.) can be found throughout this chapter and in Chapter 4, “Medical Benefits Summary.”

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. Note that charges for services that are deemed to be not medically necessary will not be deemed to be 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-certification process if you are in-network; you or your out-of-network doctor must initiate this pre-certification process if you are out-of-network. If you do not obtain pre-certification, coverage for benefits may be limited or denied entirely. The following services and supplies require pre-certification through the Care Management Program:

- Durable medical equipment and medical supplies
- Hearing aids for dependent children
- Home health care
- Hospice care
- 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-certification 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-certification)
- Temporomandibular Joint Syndrome (TMJ) treatment
- Transplant services
- Mental health and substance abuse

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 approvals for care in a hospital or special facility
- Deductibles
- Out-of-pocket maximums
- Filing claim forms

Your Out-of-Network Deductible
You and each covered dependent must pay an amount each calendar year before the EHP Plan begins to pay out-of-network 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 out-of-network deductible amounts for the EHP Classic Plan are as follows:

<table>
<thead>
<tr>
<th>Annual Deductible</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Per individual</td>
<td>$250</td>
</tr>
<tr>
<td>Per two adults</td>
<td>$500</td>
</tr>
<tr>
<td>Per parent/child</td>
<td>$500</td>
</tr>
<tr>
<td>Per family</td>
<td>$750</td>
</tr>
</tbody>
</table>

Understanding the Family Deductible Limit
If you enroll for coverage for you and your spouse or same-sex 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:

- For preventative care
- Above reasonable and customary charges
- Above any coverage limit
- For any penalties if you do not pre-certify certain services as required
- For any uncovered expenses
- As copayments
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, excluding your deductible. The out-of-pocket maximum is calculated separately for in-network care versus 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>Per individual</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>Per two adults</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Per parent/child</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Per family</td>
<td>$4,500</td>
<td>$9,000</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 Family Out-of-Pocket Maximum

If you enroll for coverage for you and your spouse, you and your spouse, or your entire family, 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. Your family won’t have to pay more out-of-pocket for the year than the family amount, up to allowed charges, whether or not you or any dependent reach the individual amount. You pay any amounts in excess of the allowed charges.

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:

- Above reasonable and customary charges
- Above any coverage limit
- For any penalties if you do not pre-certify certain services as required
- For any uncovered expenses
- As copayments

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.

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.

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 within 48 hours of the admission.
What’s Covered by the EHP Classic Plan

Preventive Care
Subject to all of the applicable limitations and provisions of the plan, services for preventive care are generally covered at 100% for services provided in-network and 70% (no deductible) for service provided out-of-network. These services include:

• Periodic 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) (no deductible for out-of-network care)
• Immunizations (included in routine office benefit)

Physician and Provider Services
Subject to all of the applicable limitations and provisions of the plan, inpatient physician services are generally covered at 80% 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 or 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
• 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, provided that the state in which such services are performed has a licensing or certification process for midwifery, and the midwife is licensed at the time delivery is performed
• Newborn care—necessary care and treatment of medically diagnosed congenital defects and birth abnormalities if the baby is eligible for enrollment and the newborn is enrolled within 30 days of birth
• Nursing services (professional) by a registered nurse or licensed practical nurse who is not a close relative (spouse, child, grandchild, brother, sister-in-law, parent, or grandparent) of the patient
• Obesity—surgical treatment for morbid obesity (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 that provided the first surgical opinion consultation; one additional consultation, as a third opinion, is eligible under this clause when the second opinion disagrees with the first (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 orthognathic surgery, limited to physical therapy, surgery, and orthodontic devices such as mouth guards and intraoral devices (excludes orthodontics and prosthetics)
• Vasectomies and tubal ligations
• Vision exam (in-network only)
• Rehabilitation services at a rehabilitation facility that is licensed to provide comprehensive rehabilitation services to patients recovering from an accident or an illness, and for evaluation and treatment of individuals with physical disabilities with emphasis on education and training. The program must be coordinated and provided by or under the supervision of physicians who are qualified and experienced in rehabilitation. These services (defined later under therapies) include but are not limited to:
  - Physical therapy
  - Occupational therapy
  - Speech and language therapy
  - Psychotherapy
- Rehabilitation nursing
- 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 improving the functional restoration of the person’s abilities lost or impaired by disease or accidental injury, to satisfactorily accomplish the ordinary tasks of daily living in the home setting (does not include maintenance therapy)
  - 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)
  - Radiotherapy (inpatient and outpatient)—the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes

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 of the applicable limitations and provisions of the plan, hospital services are generally covered at 80% after a $250 hospital copay for services provided in-network and covered at 70% after the deductible for services provided out-of-network. These services include:

• Anesthetics and oxygen, and their administration
• Emergency services (a $75 facility copay is required for in-network or out-of-network; the facility copay is waived if patient is admitted)
• 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
• 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
- Ambulance services

Mental Health and Substance Abuse Services
Pre-certification is required for all Mental Health and Substance Abuse services; benefits are not paid if services are not pre-certified. For additional information about other mental and nervous covered services, see Chapter 4, “Medical Benefits Summary.”

Health Management Programs

Health Coaching Program
As a member of Employer Health Programs (EHP), you have the opportunity to work with your very own Health Coach. Johns Hopkins University and Healthy@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) 1-800-957-9760. You can also send an email to healthyhopkins@jhhc.com.

Chronic Condition Management
Perhaps you have already been diagnosed with a chronic condition, such as asthma or diabetes. Employer Health Programs (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 at 410-762-5390 or (toll-free) 1-800-957-9760 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
- Help you work with your primary care and other specialty providers to coordinate care

To discover more about these programs, please call 410-762-5390 or (toll-free) 1-800-957-9760. Or, you can send an email to healthyhopkins@jhhc.com.
Other Covered Services and Supplies
Home health care is covered in full for services received in-network, and covered at 70% 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 and 70% 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
- Is not primarily for the convenience of the patient

Subject to all of the applicable limitations and provisions of the plan, following is a list of other services 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
  - Levator ani syndrome
- Blood products, if not replaced
- Contraceptive devices, limited to IUDs and diaphragms only
- 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 treatment is provided within 48 hours of the accident
- Diabetic supplies
- Injectable prescription drugs, both physician-administered and self-administered (however, prior authorization may be required)
- Hearing aids for dependent children up to $1,400 per aid (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
    - Infertility treatment, limited to certain artificial insemination (AI), in vitro fertilization (IVF), and/or gamete intra fallopian transfer (GIFT) procedures. Services must be pre-certified by the Care Management program. There is a $100,000 lifetime maximum (per employee) for all infertility treatment benefits combined.

The features of the medical benefits offered under the plan are also summarized briefly in a matrix found in Chapter 4, “Medical Benefits Summary.” If there are any discrepancies between the information in this document and the Plan document, the Plan document will govern.

**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

- Coverages refused by another plan as a penalty for non-compliance with that plan’s requirements
- Custodial care, residential care, or rest cures
- Dental treatment except in connection with an accidental injury to sound natural teeth that is part of the initial emergency treatment within 48 hours after the accident
- Drugs that are non-prescription, non-legend, or over-the-counter
- Drugs or devices not approved by the FDA for marketing and/or for the prescribed treatment of a specific diagnosis unless approved by the 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
- 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)
- If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, equipment, treatment or procedure is 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 dependent children as described earlier in this document)

• Hypnosis training

• Immunizations related to travel unless approved by the Center for Disease Control guidelines for the countries to be visited

• Injury sustained or an illness contracted while committing a crime

• Injury sustained while riding a motorcycle, unless the covered person was wearing a helmet approved by Maryland state law (this exclusion applies even if wearing a helmet would not have prevented or reduced the injury)

• Marital counseling

• Maternity care for persons other than you, your spouse/same-sex domestic partner, or eligible dependents

• Myopia or hyperopia correction by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy or laser surgery and all related services

• Nicotine addiction treatment or smoking cessation programs

• Obesity treatment, including surgical procedures for weight reduction or for treatment of conditions resulting from being overweight, except for surgical treatment of morbid obesity as described 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

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Medical Benefits
• Surrogate motherhood treatment, including any charges related to giving birth or for treatment of the newborn child resulting from the surrogate motherhood

• Telephone consultation charges, missed appointment charges, or charges for the completion of claim forms

• Transsexualism, gender dysphoria, or sexual reassignment or change, including medication, implants, hormone therapy, surgery, medical, or psychiatric treatment

• Treatment of educational and developmental disorders including but not limited to mental health services, diagnostic testing, physical, speech, or occupational therapy

• Treatment which is not medically necessary

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

• Treatment for which a third party may be liable, unless otherwise payable (as described under “Subrogation” in this section of the Handbook

• Treatment by a provider who is a close relative of the covered person (spouse, same-sex domestic partner, child, brother, sister, in-law, grandparent, or parent) or who resides in a covered person's home

• Vision training or eye exercises to increase or enhance visual activity or coordination

• 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 1-800-261-2393.
Description of the HMO Plan: Kaiser Permanente
A Health Maintenance Organization (HMO) is a managed health care plan that offers comprehensive medical care. 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 HMO Works
Under an HMO plan, you must use the HMO’s doctors and facilities to receive benefits. When you need specialty care, you must get a referral from your primary care physician (PCP) for services to be covered. Most eligible expenses are covered at 100% or require a small copayment. Hospital inpatient admission requires a $250 copayment.

Specific coverage information (deductible amounts, copay requirements, etc.) can be found throughout this chapter and in Chapter 4, “Medical Benefits Summary.”

Primary Care Physician
You are required to select a primary care physician (PCP) when you enroll in an HMO. Your primary care physician will be a doctor who knows you and your medical history, and can help determine the right care for you. Primary care physicians 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 primary care physician can help you determine what treatment is right for you and will recommend an appropriate provider. You must get a referral from your primary care physician for specialist services to be covered.

Your Deductible
There is no deductible.

Your Out-of-Pocket Maximum
There is no out-of-pocket maximum.

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 Kaiser Permanente 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. The coverage of your costs will vary depending upon the plan you are enrolled in.
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.

**What’s Covered by the HMO**

**Preventive Care Services**
Subject to all of the applicable limitation and provisions of the plan, 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
  - 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
  - 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

**Physician and Provider Services**
Subject to all of the applicable limitations and provisions of the plan, physician services are generally covered 100% after a $10 copay ($20 copay for specialist visits). 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
• 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
• Consultations and immunizations for foreign travel

Hospital Services
Subject to all of the applicable limitations and provisions of the plan, hospital services are generally covered at 100% after a $250 hospital copay. 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; outpatient services 100% covered after $10 copay for primary care physician or $20 copay for specialist)
  - 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
  - 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 $20 specialist copay)
• Chemotherapy and radiation therapy
• Respiratory therapy
• Medical social services and discharge planning
• Urgent care in plan area; urgent care out of plan area if life threatening or serious emergencies (emergency services require a $75 copay per hospital visit; this $75 copay is waived if the patient is admitted and the $250 hospital copay will apply)
• Ambulance services if (1) 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 (2) 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 of the applicable limitations and provisions of the plan, covered mental health and substance abuse services include:

- Therapy prescribed or directed by a physician, including
  - Individual therapy
  - Group therapy
  - 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
  - Visits for the purpose of monitoring drug therapy

For specific information about covered services, see Chapter 4, “Medical Benefits Summary.”

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. Note:

- Coverage is limited to the standard item of equipment that adequately meets your medical needs
- Repairs or replacement of equipment is covered
- Diabetes equipment and supplies are separately covered
Subject to all of the applicable limitations and provisions of the plan. Following is a list of other services covered by the plan:

- **Chiropractic services**
  - Coverage provides a discount on services if you use a Healthy Roads provider. You must show your Kaiser member ID card for the discount to apply.

- **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
  - 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
  - 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)
  - 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 3, for a period not to exceed 6 months
  - Asthma equipment (spacers, peak-flow meters, nebulizers)
  - Bilirubin lights for infants under age 3, for a period not to exceed 6 months
• Reproductive Health (see Chapter 4, “Medical Benefits Summary,” for specific information about covered services), including:
  - Pre- and post-natal care
  - Infertility services, which are limited to infertility counseling, testing, and artificial insemination and in-vitro fertilization

Coverage for infertility services usually require 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; $20 copay for ophthalmologist under Kaiser Permanente;

• 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 atresia; autologous bone marrow or stem cell transplants that are not experimental or investigational; allogenic 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
  - 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 (Note: Kaiser covers this service only if the procedure is deemed medically necessary and if the member follows a pre-surgery program specified by his or her Primary Care Physician (PCP))

• Hair prosthetics resulting from chemotherapy and/or radiation therapy

The features of the medical benefits offered under the plan are also summarized briefly in a matrix found in Chapter 4, “Medical Benefits Summary.” If there are any discrepancies between the information in this document and the Plan document, the Plan document will govern.
**What’s Not Covered**

The HMO does not cover the following services:

- Chiropractic services and the services of a chiropractor, acupuncture, naturopathy, and massage therapy, unless otherwise covered (Note: Kaiser does offer some coverage; see “Other Covered Services” above)

- 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 or cleft lip or cleft palate

- 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 any of the following statements apply to it as of the time the Service is or will be provided to you:
  - 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; or
  - 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
  - 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
- 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
• All services related to sexual reassignment

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.

Inside the Washington D.C. Metropolitan area:
(301) 468-6000

Outside the Washington D.C. Metropolitan area:
1-800-777-7902 or TDD (301) 816-6344
Visiting Other Health Plan or Allied Plan Service Areas

If you visit a service area (different from your provider service area) temporarily—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, 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
- Preventive health care services
- Emergency services
- X-ray, laboratory and special procedures
- Inpatient and outpatient chemical dependency and mental health services

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 health 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 the Medical Plan will end on the earliest of the following dates:

- The end of the month in which you end your employment or are no longer an eligible employee (such as because of a decrease in the number of hours worked or a transfer to an ineligible employee class)
- The date the Medical Plan is discontinued
- The date when you report for active duty as a member of the armed forces of any country, unless you qualify to continue Medical Plan coverage under the Johns Hopkins University Military Leave Policy
- The date on which you stop making the required contributions for coverage

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

- The date the Medical Plan ceases to provide coverage for dependents
- The end of the year in which he/she no longer qualifies as an eligible dependent under the Plan.
- The effective date of your election to drop dependent coverage
- The date the Medical Plan is discontinued
- The date on which you stop making contributions for your dependents
- The date on which your dependent enters military service

For certain of the above events, you or your dependents may be able to continue coverage by self-payment under COBRA, as explained in the section titled, “Continued Coverage Under COBRA.” If you take an approved unpaid leave of absence from your employment (including a leave covered by the Family and Medical Leave Act (FMLA)), you must continue making your required contributions for Medical Plan coverage to remain in effect. If you do not make your required contributions, your Medical Plan coverage will end. If your leave is covered under FMLA, you may be allowed to resume coverage upon your return from leave.

Certification of Coverage
Under the Health Insurance Portability and Accountability Act (HIPAA), if a group health plan includes a pre-existing condition exclusion, it must reduce the exclusion period—day for day—by any prior “creditable coverage” a participant may have. This means that you may receive credit for previous health coverage, including COBRA coverage, as long as you do not have a break in coverage of 63 days or more. Under the university Medical Plan, there are no limitations on coverage due to a pre-existing condition. However, if your coverage or your dependent's coverage under the university's Medical Plan ends, you or your dependent will automatically receive a certificate showing when coverage began and ended. You may need to furnish this certificate if you become eligible under another group health plan, or wish to buy an insurance policy, that excludes coverage for certain medical conditions that you have before you enroll.

Subrogation
As a condition to receiving benefits under the Medical 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, if you or anyone covered through you receives any recovery, by way of judgment, settlement or otherwise, from another person or entity, as a condition to receiving benefits under the Plan, 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 monies 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 a portion thereof, 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 the 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 your or the person covered through you claim without prior express written authorization by the Plan. The Plan will not be subject to any “make whole” or other similar subrogation rule.

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

If you or 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**

In the event 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.

**Converting Coverage**

If you have fully-insured coverage, when your university coverage ends, you may be able to convert your coverage to an individual policy directly with the carrier. Conversion procedures are handled directly by each medical plan carrier. You must apply for conversion within 30 days after your university coverage ends by contacting member services.
Coordination of Benefits

When You Have Other Coverage

The university’s group health care 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 same-sex domestic partner’s plan at work. What this means is that if benefits are payable under another plan, your benefit from the university 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

• 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—the university plan is your primary coverage

    - For your covered spouse or same-sex domestic partner—the plan provided by his or her employer is primary

    - For your covered children or your covered same-sex domestic partner’s children—the birthday rule determines which plan is primary. The plan covering the children through your spouse/same-sex domestic partner whose birthday falls earlier in the year is primary for the children. If you and your spouse/same-sex domestic partner have the same birthday, the plan covering the children through you or your spouse/same-sex 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).

The university 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 the university plan is secondary, subtract B from A, as shown below:

| A | 100% of “allowable expenses” incurred by the person for whom the claim is made |
| B | Benefits payable by the “other plans” |

**In case of divorce or legal separation,** the dependent child's or child of a same-sex domestic partner's primary plan is determined in the following order:

- The plan covering the parent who has financial responsibility for medical expenses according to 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 same-sex domestic partner (if any) of the parent with legal custody of the child
  - Then, the plan of the natural parent without custody of the child

If there is a court decree which states the parents share joint custody of a dependent child, without stating that one of the parents is responsible for health care expenses of the child, then, the birthday rule determines which plan (the university's or your spouse's/same-sex domestic partner's) is primary. The plan covering the spouse/same-sex domestic partner whose birthday falls earlier in the year is primary. If you and your spouse/same-sex domestic partner have the same birthday, the plan covering you or your spouse/same-sex domestic partner for the longer period of time is primary.

If the above rules do not establish an order of payment, the plan under which the person has been covered the longest will pay benefits first, except as follows:

- The benefits of a plan which covers a laid-off or retired employee (or a dependent spouse/dependent same-sex domestic partner/child of dependent spouse or same-sex domestic partner) will be determined after benefits of any other plan have been taken into account. This does not apply if the other plan does not have a similar provision.
- The benefits of a plan for someone who has a right of continuation pursuant to federal or state law will be determined after benefits of any other plan which covers that individual, other than under such right of continuation. This does not apply if the other plan does not have a similar provision.

All medical plan carriers have the right to release or obtain any information and make or recover any payment it considers necessary in order to administer these coordination of benefits rules.
Coordination of Benefits with Medicare

When eligible for Medicare, if you continue to work for the university after age 65 you may continue your medical coverage under the university plan and coordinate this plan with Medicare. In general, this plan would be primary and pay benefits first for:

- Eligible employees age 65 and over with current employment status and opposite-sex spouses age 65 and over who participate in the university plan on the basis of the employee’s current employment status.
- Social Security disabled individuals who are covered by the university 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 (e.g., disabled opposite-sex spouses or dependents of an active employee, or Social Security disabled participants who have returned to work).
- 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.

You may choose to elect Medicare as primary coverage by opting out of coverage under the university plan. If you choose this option, your covered dependents are eligible for continuation of coverage under COBRA for up to 36 months. Contact the Benefits Service Center for more information.

Your JHU Medical Plan provides prescription drug benefits that are at least as financially generous as Medicare prescription drug plan coverage.

- If you do enroll in a Medicare Prescription Drug Plan—so-called “Medicare Part D” benefits—you will continue to be enrolled in the JHU Medical Plan. You will have to pay an additional Medicare premium (although the premium is reduced or eliminated for individuals who qualify for special assistance based on income and assets). Your JHU prescription drug benefits may be reduced by benefits payable under Medicare.
- If you do not enroll in a Medicare Prescription Drug Plan, you will continue to be enrolled in the JHU Medical Plan. You won’t have to pay an additional Medicare monthly premium. You will not have to pay a late enrollment penalty if you decide to enroll in a Medicare prescription drug plan at a later time immediately after your university plan coverage ends.

If you are on disability, after receiving Social Security disability for two years, Medicare becomes your primary coverage. Coverage through the university plan (if it is still available) is secondary.

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

Filing Claims Under All Health Care Options

Following is general information that applies to filing claims under the university Medical Options (CareFirst BlueCross BlueShield and EHP Classic), Dental Options, and claims for prescriptions filled at non-participating pharmacies. Detailed information can be found in the Plan Administration section. Note that there 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 more than one year after the normal filing deadline, unless the charges relate to a previous claim already on file; this one year period will be “suspended” during periods in which you are legally incapacitated. Here’s how to claim medical, dental, and prescription drug 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.
• 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.
• Receive an Explanation of Benefits (EOB)
  - You will receive an 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.

Situations Affecting Your Health Care Coverage

If You Leave the University
Your medical coverage ends on the last day of the month following 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 you separate from service with the university and meet the eligibility requirements for retiree benefits (see Chapter 10, “Medical and Dental Benefits for Retirees”), you and your dependents may be eligible for retiree health care coverage under the university’s group health plan.

If You Are on a Leave of Absence
If you elect to continue medical benefits while on a leave of absence, you must pay your share of the premium on a monthly basis.

Dependent Coverage If You Die While a University Employee
Coverage for your eligible dependents will continue until the end of the month following the month in which you die. Your dependents may be able to elect to continue coverage. Detailed information on continuation coverage can be found under “Continued Coverage Under COBRA” in this section.

If you die while an active employee and have met the eligibility requirements for retiree health benefits, your dependents may be able to elect to continue coverage under the university’s retiree medical plan.

If You Take Military Leave
If you take military leave under 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 the university advance notice (with certain exceptions) of the leave, and provided that your total leave, when added to any prior periods of military leave from the university, 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 (including the university’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 reemployment when determining whether an exclusion or waiting period, if any, applies upon your reinstatement to the plan. (Exclusions may be allowed for an illness or injury that was incurred or aggravated during the period of uniformed service.)

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 your employment is terminated involuntarily due to reduction in force and you are then rehired within 12 months OR if you voluntarily resign in good standing and are rehired within 6 months following your termination, you will automatically be enrolled in the myChoices Program benefits plans, except for Flexible Spending Accounts, that were in place prior to your termination. (Note: you must have been employed for one continuous year in a benefits eligible status prior to your termination.) You can also make new elections upon rehire.

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.

Continued Coverage Under COBRA

This section of your Summary Plan Description applies to employees and covered spouses and covered dependent children who have health coverage under the Plan. Note that COBRA applies only to the medical, prescription drug, dental, vision and health care flexible spending account benefits described in this Summary and not to any other type of benefit.

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 that 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 or her covered opposite-sex spouse, and his or her dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. (See the end of this section for a discussion of how the Plan’s continuation of coverage rules apply to same-sex domestic partners and dependent children of same-sex domestic partners.) 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.

Opposite-sex spouses of employees will become qualified beneficiaries if they lose your 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 or 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 or 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 the Employer, 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 opposite-sex spouse, surviving opposite-sex 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 opposite-sex 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 opposite-sex 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.”
- 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 opposite-sex spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage. (NOTE: The rest of this paragraph applies to health benefits other than a health care flexible spending account. For the rules that apply to the health care flexible spending account, 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 8 months before the date on which his employment terminates, COBRA continuation coverage for his 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 8 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, opposite-sex spouse or dependent child covered under the Plan is determined by the Social Security Administration to be disabled 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 or 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.

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 opposite-sex spouse and dependent children in the family can get up to 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 opposite-sex 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 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 (plus any grace period that applies after the end of that Plan Year (as described in this Summary Plan Description), but only if the qualified
beneficiary keeps COBRA coverage in effect through the last day of the Plan Year). 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 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 (including any grace period rules) for filing a request for reimbursement under the Health FSA, as described earlier in this Summary Plan Description, will continue to apply if continuation coverage is elected under the Health FSA.

**Additional Continuation Coverage Election Period for “TAA-Eligible Individuals“**

In addition to the other COBRA rules described in this Summary Plan Description, there are some special rules that apply if an employee is classified as a “TAA-eligible individual” by the U.S. Department of Labor. (This applies only to someone who qualifies for assistance under the Trade Adjustment Assistance Reform Act of 2002 because he or she becomes unemployed as a result of increased imports or the shifting of production to other countries.)

If an employee is classified by the Department of Labor as a TAA-eligible individual, and he or she does not elect COBRA continuation coverage when he or she first loses coverage, the individual may qualify for an election period that begins on the first day of the month in which he or she becomes a TAA-eligible individual and lasts up to 60 days. However, in no event can this election period last later than six months after the date of the TAA-related loss of coverage. If an individual elects continuation coverage during this special election period, the continuation coverage would begin at the beginning of that election period, but, for purposes of the required coverage periods described in this section, the coverage period will be measured from the date of your TAA-related loss of coverage.

The Trade Adjustment Assistance Act also provides for a tax credit of 80% of the cost of premiums paid for qualified health insurance before January 1, 2011. Affected individuals should consult with a financial adviser about questions about the tax credit.

**Early Termination of Continuation Periods**

In some cases, the COBRA continuation periods noted above terminate early. If you experience a COBRA qualifying event and provide any required notice by the applicable deadline, you will receive a COBRA Notice that discusses these early termination rules.
If You Have Questions

Questions concerning COBRA continuation coverage rights should be addressed to the Plan Administrator at the address indicated below. 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 the 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 Same-sex Domestic Partners and Dependent Children of Same-sex Domestic Partners

The JHU health plans currently voluntarily provide “COBRA-like” health care continuation benefits to covered same-sex domestic partners and covered dependent children of same-sex domestic partners under terms similar to those that apply to opposite-sex spouses and dependent children entitled to COBRA rights under federal law. Same-sex domestic partners and covered children of same-sex 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.

For Other Information, Go To...

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Description of the BlueChoice HMO Plan—This plan is closed to new participants effective January 1, 2010

BlueChoice is a Health Maintenance Organization (HMO) — a managed health care plan that offers comprehensive medical care. Under an HMO plan, you must use the HMO’s doctors and facilities to receive benefits. When you need specialty care, you must get a referral from your primary care physician (PCP) for services to be covered. 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. Specific coverage information (deductible amounts, copay requirements, etc.) can be found throughout the remaining chapter.

Coverage Levels
The available coverage levels under BlueChoice are:
• Individual—faculty or staff member
• Parent and Child(ren)—faculty or staff member and one or more children
• Two Adults—faculty or staff member and spouse or same-sex domestic partner* and one or more children
• Family—faculty or staff member, spouse or same-sex domestic partner* and one or more children

*Must qualify for coverage under the Johns Hopkins University Same-sex Domestic Partnership Benefits Policy

Primary Care Physician
You are required to select a primary care physician (PCP) when you enroll in an HMO. Your primary care physician will be a doctor who knows you and your medical history, and can help determine the right care for you. Primary care physicians 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 primary care physician can help you determine what treatment is right for you and will recommend an appropriate provider. You must get a referral from your primary care physician for specialist services to be covered.

Your Deductible
There is no deductible.

Your Out-of-Pocket Maximum and Copayment Maximum
There is no out-of-pocket maximum or copayment maximum, which is the amount of copays you or those covered through you make in a plan year.

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. The coverage of your costs will vary depending upon the plan you are enrolled in.
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.

**What’s Covered by BlueChoice**

**Preventive Care Services**
Subject to all of the applicable limitations and provisions of the plan, preventive care services are generally covered at 100% after a $10 copay per visit. 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
  - 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
  - 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

**Physician and Provider Services**
Subject to all of the applicable limitations and provisions of the plan, physician services are generally covered 100% after a $10 copay ($20 copay for specialist visits). 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
• Consultations and immunizations for foreign travel

Hospital Services
Subject to all of the applicable limitations and provisions of the plan, hospital services are generally covered at 100% after a $250 hospital copay. 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; outpatient services 100% covered after $10 copay for primary care physician or $20 copay for specialist)
  • 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
  • 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 $20 specialist copay)
• Chemotherapy and radiation therapy
• Respiratory therapy
• Medical social services and discharge planning
• Urgent care in plan area; urgent care out of plan area if life threatening or serious emergencies (emergency services require a $75 copay per hospital visit; this $75 copay is waived if the patient is admitted and the $250 hospital copay will apply)
• Ambulance services if (1) 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 (2) 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 of the applicable limitations and provisions of the plan, covered mental health and substance abuse services include:
• Therapy prescribed or directed by a physician, including
- Individual therapy
- Group therapy
- 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
  - Visits for the purpose of monitoring drug therapy

For specific information about covered services, please see the [medical benefits summary](#) at the end of this section.

**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. Note:

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

Subject to all of the applicable limitations and provisions of the plan. Following is a list of other services 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 older

- **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
  - 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
  - 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
  - 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 3, for a period not to exceed 6 months
  - Asthma equipment (spacers, peak-flow meters, nebulizers)
  - Bilirubin lights for infants under age 3, for a period not to exceed 6 months

• Reproductive Health (see the BlueChoice medical plan chart for specific information about covered services), including:
  - Pre- and post-natal care
  - Infertility services, which are limited to infertility counseling, testing, and artificial insemination and in-vitro fertilization

Coverage for infertility services usually require 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 artesia; autologous bone marrow or stem cell transplants that are not experimental or investigational; allogenic 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
- 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 plan

- Custodial care services

- Surgical treatment of morbid obesity

- Hair prosthetics resulting from chemotherapy and/or radiation therapy

The features of the medical benefits offered under the plan are also summarized briefly in the BlueChoice medical plan chart. If there are any discrepancies between the information in this document and the Plan document, the Plan document will govern.

**Prescription Drug Benefits**
Medco administers prescription drug benefits for the BlueChoice Medical Plan. See page 3.4 for a description of how your prescription drug benefits work and page 3.59 for coverage amounts.

**What’s Not Covered**
The following services are not covered under BlueChoice:

- 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 or cleft lip or cleft palate

- 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 any of the following statements apply to it as of the time the Service is or will be provided to you:

  - 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; or
  - 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
  - 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
- 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

- All services related to sexual reassignment

**Visiting Other Health Plan or Allied Plan Service Areas**

If you visit a service area (different from your provider service area) temporarily—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.

**Other Helpful Information**

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<td>Medical Benefits beginning on page 3.38</td>
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<td>When Coverage Ends</td>
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<td>Certification of Coverage</td>
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<td>Filing Claims (Note: The general information applies in this section except BlueChoice will only pay the member if the provider is non-participating with BlueChoice)</td>
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<td>Situations Affecting Your Health Care Coverage</td>
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<td>Continued Coverage Under COBRA</td>
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<td>How the myChoices Program Works</td>
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<tr>
<td>How the Plan is Administered and Your ERISA Rights</td>
<td>Administrative Information</td>
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# BlueChoice Medical Benefits Summary

*Note: The following is a summary and subject to all of the provisions of the plan as described previously. If there are any discrepancies between the content of this matrix and the Plan document, the document will govern.*

<table>
<thead>
<tr>
<th>Benefits</th>
<th>BlueChoice (HMO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual deductible (does not apply to out-of-pocket maximum)</td>
<td>None</td>
</tr>
<tr>
<td>Annual out-of-pocket-maximum</td>
<td>None</td>
</tr>
<tr>
<td>Dependent eligibility</td>
<td>Legally married spouse or same-sex domestic partner (if qualified for coverage under Johns Hopkins University Same-sex Domestic Partnership Benefits Policy) may be covered Child(ren) who do not have access to their own employer coverage may be covered up until the end of the year in which they turn age 26; coverage may continue for children up to any age if they cannot support themselves because of a mental or physical disability that occurred before they reached the age limit when coverage would normally end</td>
</tr>
</tbody>
</table>

## Preventive Care

<table>
<thead>
<tr>
<th>Preventive care including physical exams and well baby</th>
<th>$10 PCP copay per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations (adult) and mammograms</td>
<td>100% covered</td>
</tr>
</tbody>
</table>

## Physician Services

<table>
<thead>
<tr>
<th>Physician services (office visit)</th>
<th>$10 PCP copay per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$20 specialist copay per visit</td>
</tr>
<tr>
<td>Physician services (medical and surgical)</td>
<td>Inpatient 100% covered; outpatient $10 PCP copay may apply $20 specialist copay</td>
</tr>
</tbody>
</table>

## Hospital Services

<table>
<thead>
<tr>
<th>Hospital copay per inpatient admission (not subject to deductible)</th>
<th>$250 per inpatient admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital service benefits (inpatient)</td>
<td>100% covered after $250 hospital copay</td>
</tr>
<tr>
<td>Emergency care (sudden and serious and accidental injury)</td>
<td>$75 copay for Emergency Room (waived if admitted)</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>$10 PCP copay per visit $20 specialist copay per visit</td>
</tr>
</tbody>
</table>

## Mental Health/Substance Abuse

<table>
<thead>
<tr>
<th>Mental health (inpatient)</th>
<th>100% covered; subject to authorization from Magellan; $250 copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health (outpatient)</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Substance abuse (inpatient)</td>
<td>100% covered after $250 inpatient copay</td>
</tr>
<tr>
<td>Substance abuse (outpatient)</td>
<td>$10 copay  partial hospitalization at $10 per day</td>
</tr>
</tbody>
</table>
### Benefits

<table>
<thead>
<tr>
<th>Reproductive Health</th>
<th>BlueChoice (HMO)</th>
</tr>
</thead>
</table>
| Pre- and post-natal care | 1-877-691-5856  
|                      | www.carefirst.com |
| Family planning & fertility testing | $10 PCP copay per visit  
|                                   | $20 specialist copay per visit |
| Artificial insemination | 50% of allowable charges |
| In vitro fertilization | 50% of allowable charges; $100,000 lifetime maximum or 3 attempts per live birth |

| Prescription Drugs | |
|--------------------| Administered by Medco Health Solutions |
| Retail (up to a 30-day supply) | $10 Generic  
|                                   | $20 Formulary brand  
|                                   | $35 Non-formulary brand |
| Mail order | Up to a 90-day supply for maintenance drugs:  
|           | $20 Generic  
|           | $40 Formulary brand  
|           | $70 Non-formulary brand |