All Children's Health System Health and Welfare Plan

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Summary Plan Description

for the

EHP Medical Plan

Exclusive Provider Organization Benefits

January 1, 2025

Important Contact Information

Claims or Coverage Questions	Johns Hopkins EHP Customer Service HR Support Center	410-424-4450 or 800-261-2393 www.ehp.org 443-997-5400
Utilization Management Prior authorization of services	Johns Hopkins EHP	410-424-4480
COBRA Questions	HealthEquity (WageWorks)	877-502-6272
Claim Forms	Johns Hopkins EHP	www.ehp.org
Confidential Help With Personal Problems	Johns Hopkins Employee Assistance Program	888-978-1262

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GENERAL INFORMATION

General Information About Your Benefits

All Children's Health System, Inc. offers you and your family health care benefits under the EHP Medical Plan to help you pay for medical care when you need it.

These benefits are provided under the All Children's Health System Health and Welfare Plan and are described in this Summary Plan Description (SPD).

The benefits described in this SPD are provided for eligible employees of All Children's Health System, Inc. The benefits are also provided for eligible employees of Johns Hopkins All Children's Hospital, Inc., Johns Hopkins All Children's Foundation, Inc., Johns Hopkins All Children's Urgent Care, Inc., All Children's Research Institute, Inc., All Children's Community Network, LLC, ForAllKids, LLC, Pediatric Physician Services, Inc. and West Coast Neonatology, Inc. All these employers are collectively referred to in this SPD as "All Children's".

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

This SPD only applies to claims incurred on or after January 1, 2025.

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

GENERAL INFORMATION

Who Is Eligible

Employee Coverage

Regular Eligibility Rules

Full-Time Employees (regularly scheduled to work 40 or more hours per week) and Part-Time Employees (regularly scheduled to work at least 20 hours per week) of All Children's are generally eligible for the benefits described in this SPD.

Employees of the Johns Hopkins Health System Corporation who are assigned to primarily work at All Children's are also eligible for the benefits described in this SPD if they meet the eligibility requirements under the Johns Hopkins Health System Corporation/The Johns Hopkins Hospital EHP Medical Plan.

Special Eligibility Rules

Affordable Care Act "Full-Time Employees"

If you are not eligible under the Regular Eligibility Rules set forth above, you will be eligible for the EHP Medical Plan for any month in a "Stability Period" for which you are an "ACA Full-Time Employee" and you are employed by All Children's. Whether you are an ACA Full-Time Employee is determined by All Children's in accordance with regulations issued under the Affordable Care Act and Internal Revenue Code Section 4980H. Those regulations provide the following general rules:

- You are an ACA Full-Time Employee for a Stability Period if during the immediately preceding Initial or Standard Measurement Period you worked an average of 30 hours per week.

- Your Initial Measurement Period is the eleven month period starting with the first full pay period beginning after your date of hire. You only have one Initial Measurement Period. However, if you terminate employment and are rehired after 90 or more days, you will have a new Initial Measurement Period. (Other special rules can apply for rehires.)

- The Standard Measurement Period is the twelve month period from October 3 of one year to October 2 of the following year. There is a new Standard Measurement Period every year.

- Your first Stability Period is the twelve calendar months starting with the first day of the month that begins at least 30 days after the end of your Initial Measurement Period. Thereafter, your Stability Period is the twelve calendar months starting with the January that follows the Standard Measurement Period.

If you are not eligible under the Regular Eligibility rules, but you are an ACA Full-Time Employee, you will be notified before the beginning of the Stability Period that you are eligible to elect EHP Medical Plan coverage. Your eligibility for coverage terminates at the end of the Stability Period, unless you continue to be an ACA Full-Time Employee for the following Stability Period or you become eligible under the Regular Eligibility rules.

Dependent Coverage

Eligible dependents may also be covered under the EHP Medical Plan for any month for which you are eligible as explained above. Eligible dependents are:

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

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

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

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

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

Domestic Partner Coverage

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

Qualified Medical Child Support Order (QMCSO)

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

When Coverage Begins

Coverage under the EHP Medical Plan begins on your date of hire, if you are benefits eligible under the Regular Eligibility Rules set forth above and you complete the online enrollment process within 30 days from your first day of work. To be eligible under the Regular Eligibility Rules, you must be a full-time employee who is regularly scheduled to work at least 40 hours per week, or a part-time employee who is regularly scheduled to work at least 20 hours per week. You are not eligible if you are classified by your employer as a temporary employee or if you are included in a unit of employees covered by a collective bargaining agreement that does not expressly provide for participation in the Plan. If you do not complete the online enrollment process within 30 days from your first day of work, you will not have coverage until the next annual open enrollment unless you have a family status change or qualify for ***Special Enrollment*** as explained in the Special Enrollment Rights for EHP Medical Coverage section.

If you are employed in a position that is not benefits eligible as explained above, and you change to a benefits eligible position under the Regular Eligibility Rules, coverage begins the first day of the month after the change takes effect, provided you complete the online enrollment process within 30 days from the effective date of the change.

If you are eligible under the Special Eligibility Rules for EHP Medical Plan described above, coverage begins as explained in that section.

In order for coverage to be effective, you must be actively at work on the first day of coverage performing your usual duties during your usual working hours. If you are absent from work due to a

Paid Time Off (PTO) day, vacation day, holiday, jury duty or other similar reasons, you will still be considered actively at work and coverage will be effective.

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

Changing Your Coverage

During the annual open enrollment period, you may change your EHP Medical Plan coverage. Outside of the annual open enrollment period, you may start or stop coverage, add new dependents, or drop a dependent from your coverage *only* if you have a qualifying family status change or a ***Special Enrollment*** situation (see the **Special Enrollment Rights for EHP Medical Coverage** section).

Examples of IRS-qualified changes in family status include:

♦ Marriage, legal separation, annulment or divorce;

♦ Birth, death or adoption of a dependent;

♦ Placement for adoption of a dependent;

♦ A change in employment status (for example: you or your dependent terminate employment or start a new job);

♦ A change from full-time to part-time employment (or vice versa) by you or your dependent;

♦ A change in your or your dependent's employment status due to an unpaid leave of absence;

♦ Your dependent becomes eligible or is no longer eligible for coverage under the Plan;

♦ Your spouse elects to add or drop coverage during open enrollment under your spouse's plan;

♦ You are required to cover your child due to a QMCSO;

♦ You or your dependent gain or lose eligibility for Medicare or Medicaid (you may change the current election for the affected person only); and

- Any other event that the Plan Administrator determines to qualify as a family status change under the Internal Revenue Code.

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

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

Special Enrollment Rights for EHP Medical Coverage

Losing other coverage

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

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

New Children

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

Marriage

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

Medicaid and Children's Health Insurance Program

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

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

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

Coverage Costs

All Children's pays the majority of the cost of your coverage under the EHP Medical Plan. All Children's also offers you cash rewards under the Healthy at Hopkins wellness program, which you can use to help cover the cost of those benefits that require employee contributions, including the EHP Medical Plan.

Required employee contributions are deducted from your paycheck on a pre-tax basis. Because your contributions are deducted before taxes, you reduce your taxable income and save on federal income and Social Security taxes.

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

GENERAL INFORMATION

For the exact contributions required by the EHP Medical Plan, please refer to your enrollment materials or contact the HR Support Center.

EHP MEDICAL PLAN – EXCLUSIVE PROVIDER ORGANIZATION

The EHP Medical Plan – Exclusive Provider Organization

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

Network Providers

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

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

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

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

Primary Care Physicians

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

A good way to receive consistent, quality health care is by establishing a relationship with your PCP. PCPs help guide your care including specialists, lab work and prescriptions and focus on preventing problems before they begin. Using your PCP's office as your first contact for most medical needs helps you get the care you need when you need it.

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

Three Ways to Receive Care

Under the Exclusive Provider Organization, the EHP Medical Plan offers ***three*** ways to receive care.

- The highest level of benefits is paid for treatment by EHP Select Pediatric providers.
- The next highest level of benefits is paid for treatment by EHP Preferred providers.
- A lower level of benefits is paid for treatment by EHP or Cigna PPO Network providers that are not EHP Preferred providers.

Except as described under ***Special Rules for Certain Treatment by Out-of-Network Providers***, ***Ambulance Services***, ***Air Ambulance Transportation***, ***Emergency Care*** and ***Care Received Outside the United States*** later in this SPD, no benefits are paid for treatment by providers that are not EHP Preferred, EHP Select Pediatric or EHP/Cigna PPO Network providers.

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

EHP Preferred Providers and Network Providers

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

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

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

There are no claims to file — EHP Preferred and EHP/Cigna PPO Network providers receive payment directly from the Plan.

EHP MEDICAL PLAN – EXCLUSIVE PROVIDER ORGANIZATION

Preventive care services from EHP Preferred and EHP/Cigna PPO Network providers are usually covered at 100%. Most inpatient services also require a $250 copay per admission, and a small copay applies to certain other services. The **Medical Benefits At-A-Glance** chart later in this SPD lists the specific coinsurance and copay amounts.

The following hospitals are EHP Preferred providers:

- Sarasota Memorial Hospital
- Bayfront Health St. Petersburg
- Moffitt Cancer Center
- Tampa General Hospital
- Johns Hopkins Hospital
- Johns Hopkins Bayview Medical Center
- Johns Hopkins Howard County Medical Center
- Suburban Hospital
- Sibley Memorial Hospital
- Mt. Washington Pediatric Hospital
- Anne Arundel Medical Center
- Greater Baltimore Medical Center

Physicians associated with the following groups are EHP Preferred providers:

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

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

EHP Select Pediatric Providers

EHP MEDICAL PLAN – EXCLUSIVE PROVIDER ORGANIZATION

Most treatment from EHP Select Pediatric providers is covered at 100%, with no annual deductible.

An annual out-of-pocket maximum (explained below) applies to treatment from EHP Select Pediatric providers.

There are no claims to file — EHP Select Pediatric providers receive payment directly from the Plan.

The following providers are EHP Select Pediatric providers:

- Johns Hopkins All Children's Hospital, including services provided by Hospital physicians at Hospital facilities and outpatient care centers
- Johns Hopkins All Children's Specialty Physicians (West Coast Neonatology and Pediatric Physician Services)

Deductible and Out-of-Pocket Maximum

Annual deductible

EHP Preferred and EHP/Cigna PPO Network Providers

Your calendar year annual deductible is $500 per person and $1,000 per family.

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

EHP Select Pediatric Providers

No annual deductible applies to services from EHP Select Pediatric providers.

Annual medical out-of-pocket maximum

EHP Preferred and EHP/Cigna PPO Network Providers

After you meet the annual deductible, you pay the applicable coinsurance percentage (usually 10% or 20%) until you reach an annual medical out-of-pocket maximum. After you reach the medical out-of-pocket maximum, benefits for covered services are paid at 100% for the remainder of that calendar year.

Your annual medical out-of-pocket maximum is $3,000 per person and $6,000 per family.

EHP MEDICAL PLAN – EXCLUSIVE PROVIDER ORGANIZATION

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

EHP Select Pediatric Providers

The same annual medical out-of-pocket maximum applies to services from EHP Select Pediatric providers as applies to services from EHP Preferred and EHP/Cigna PPO Network providers.

Out-of-Network Providers are not Covered

Except as described under ***Special Rules for Certain Treatment by Out-of-Network Providers***, ***Ambulance Services***, ***Air Ambulance Transportation***, ***Emergency Care*** and ***Care Received Outside the United States*** later in this SPD, the Plan does not pay benefits if you receive services or supplies from an "Out-of-Network" provider that is not an EHP Preferred, EHP Select Pediatric or EHP/Cigna PPO Network provider.

Payment Terms You Should Know

The following terms are used throughout this SPD.

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

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

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

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

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

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

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

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

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

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

The **prescription drug out-of-pocket maximum** applies to copays and coinsurance under the ***Prescription Drug Benefit*** for drugs obtained from an EHP Network Pharmacy. After prescription drug copays and coinsurance that you pay reach the annual prescription drug out-of-pocket maximum of $4,100 per person and $8,200 per family, you pay no copays or coinsurance for covered prescription drugs for the remainder of that calendar year.

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

EHP MEDICAL PLAN – EXCLUSIVE PROVIDER ORGANIZATION

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

Prior Authorization Requirement – Utilization Management

Certain services and supplies are not covered by the EHP Medical Plan unless they receive prior authorization. Your EHP Preferred, EHP Network or EHP Select Pediatric provider will request prior authorization for you from EHP Utilization Management. Cigna handles prior authorization requests if you receive care from a Cigna PPO Network provider who is not in the EHP Network. **Unless prior authorization is received, there is no coverage for the services and supplies in question.** The services and supplies that currently require prior authorization are set forth in the ***Medical Benefits At-A-Glance*** chart and under ***Covered Services and Supplies*** later in this SPD.

Because medical treatments are constantly changing, Johns Hopkins EHP and Cigna can determine that prior authorization is required for additional services and supplies not shown in this SPD. EHP Preferred, EHP/Cigna PPO Network and EHP Select Pediatric providers have access to an updated list of additional services and supplies that require prior authorization, and will request prior authorization as needed. Contact information for Cigna is on your EHP Medical Plan Identification card, or call EHP Customer Service at 410-424-4450 or 800-261-2393.

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

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

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

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

- If you receive treatment at an EHP Select Pediatric provider facility, no cost sharing requirements will apply to the Out-of-Network provider charges.

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

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

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

Notice and Consent Exception

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

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

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

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

Charges by an Out-of-Network provider that could be eligible for the notice and consent exception described above are not covered by the EHP Medical Plan under any circumstances. This rule applies regardless of whether or not the provider gives you advance written notice that you will be responsible for the charges, and regardless of whether or not you (or your authorized representative) consent to be responsible for the charges.

Continuity of Care

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

You will be notified that the provider or facility is leaving the Network or stops being an EHP Select Pediatric provider, and of your right to notify the EHP Medical Plan that you need continuing transitional care. If you notify the EHP Medical Plan that you need continuing transitional care, you will be given the opportunity to elect continuing transitional care from the provider or in the facility. If you make the continuing transitional care election, your treatment by that provider or in that facility as a continuing care patient will be covered by the Plan as though the provider or facility had not left the Network or stopped being an EHP Select Pediatric provider. This continuing transitional care will last until 90 days after the notice that the provider or facility is leaving the Network or will stop being an EHP Select Pediatric provider was sent to you, or until you are no longer a continuing care patient of that provider or in that facility, whichever comes first.

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

- undergoing a course of treatment for a serious and complex condition
- undergoing a course of institutional or inpatient care
- scheduled to undergo nonelective surgery, including receipt of postoperative care

- pregnant and undergoing a course of treatment for the pregnancy, or
- determined to be terminally ill (meaning a life expectancy of six months or less) and is receiving treatment for such illness

Serious and complex condition means:

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

Care Management Programs

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

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

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

- ♦ **Complex Care** -- if you are faced with a serious medical event or a long-term health condition, care management can provide support by coordinating care, understanding and managing your medical event or condition, and facilitating necessary services covered by your EHP Medical Plan benefits.

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

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

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

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

Diabetes Prevention Program

Diabetes prevention treatment by EHP Preferred and EHP/Cigna PPO Network providers under the Diabetes Prevention Program is covered at 100% with no deductible. The Program is designed for persons with prediabetes or who are at risk for developing type 2 diabetes. The Program is not for persons who are already diagnosed with type 1 or type 2 diabetes. The Program is a 12 month long curriculum focusing on lifestyle changes with resources and coaching support.

For more information about the Program and its eligibility requirements, visit the Program's website at www.hopkinsmedicine.org/dpep/diabetes-prevention-program, or call 410-614-2701.

Health Education

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

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

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

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

EHP Customer Service

EHP MEDICAL PLAN – EXCLUSIVE PROVIDER ORGANIZATION

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

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

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

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

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

What's Covered by the EHP Medical Plan

Medical Benefits At-A-Glance

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

SERVICES PROVIDED	EHP/Cigna NETWORK PROVIDERS	EHP PREFERRED PROVIDERS	EHP SELECT PEDIATRIC PROVIDERS
CALENDAR YEAR DEDUCTIBLE			
Per person (combined providers)	$500	$500	None
Per family (combined providers)	$1,000	$1,000	None
OUT-OF-POCKET MAXIMUM (incl deductibles, coinsurance and copays)			
Per person (combined providers)	$3,000 Medical $4,100 Prescription Drugs	Combined with EHP/Cigna Network providers	
Per family (combined providers)	$6,000 Medical $8,200 Prescription Drugs	Combined with EHP/Cigna Network providers	
1. TREATMENT OF ILLNESS OR INJURY			
Primary care office visit for medical treatment, adult and pediatric	100% after $20 copay (no deductible)	100% after $20 copay (no deductible)	100%
Specialty care office visit	80% after deductible	90% after deductible	90%
Diagnostic services and treatment in the office	Primary care office: 100% (no deductible) Specialty office: 80% after deductible	Primary care office: 100% (no deductible) Specialty office: 90% after deductible	100%
2. PREVENTIVE SERVICES			
General preventive exam (adult physical, GYN and well child care)	100% (no deductible)	100% (no deductible)	100%
Diagnostic services for exam	100% (no deductible)	100% (no deductible)	100%
Mammogram and well-woman care	100% (no deductible)	100% (no deductible)	100%
Screening colonoscopy	100% (no deductible)	100% (no deductible)	100%
Routine hearing exam	100% (no deductible)	100% (no deductible)	100%
Diabetes Prevention Program	100% (no deductible)	100% (no deductible)	Not available

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

EHP Preferred, EHP/Cigna PPO Network and EHP Select Pediatric providers have agreed to accept the EHP fee schedule as full payment and will not balance bill, other than required copays, coinsurance and deductibles.

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

MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP/Cigna NETWORK PROVIDERS	EHP PREFERRED PROVIDERS	EHP SELECT PEDIATRIC PROVIDERS
3. IMMUNIZATIONS AND INOCULATIONS			
As recommended by Centers for Disease Control and Prevention	100% (no deductible)	100% (no deductible)	100%
Travel immunizations	100% (no deductible)	100% (no deductible)	100%
4. ALLERGY TESTS AND PROCEDURES			
Allergy tests	80% after deductible	90% after deductible	100%
Desensitization materials/serum	80% after deductible	90% after deductible	100%
5. LABORATORY			
Laboratory tests and pathology	80% after deductible	90% after deductible	100%
6. RADIOLOGY			
All imaging studies, including x-rays, ultrasound, CT scans, PET scans and MRIs	80% after deductible	90% after deductible	100%
7. SURGERY			
Professional fees for inpatient surgery; prior authorization required	80% after deductible	90% after deductible	100%
Professional fees for outpatient surgery	80% after deductible 85% after deductible at ambulatory surgery center	90% after deductible 95% after deductible at ambulatory surgery center	100%
Surgical treatment for morbid obesity; prior authorization required	Bayview Medical Center, Sibley Memorial Hospital and Tampa General Hospital only	$150 copay, then 90% after deductible Bayview Medical Center, Sibley Memorial Hospital and Tampa General Hospital only	Not available
8. REPRODUCTIVE HEALTH			
Physician office visits (prenatal care only)	Routine prenatal visits 100%; All other prenatal visits 80% after deductible	Routine prenatal visits 100%; All other prenatal visits 90% after deductible	100%
Inpatient maternity care and delivery, including professional fees, lab and X-ray services; prior authorization required	$250 copay, then 80% after deductible	$250 copay, then 90% after deductible	100%
Newborn nursery care and NICU	80% after deductible; $250 copay for NICU	90% after deductible; $250 copay for NICU	100%
Birthing center facility charges	90% after deductible	Not available	100%
Birthing center professional fees	80% after deductible	90% after deductible	100%
Contraceptive devices	100% (no deductible)	100% (no deductible)	100%

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

Only medically necessary services and supplies are covered.

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

SERVICES PROVIDED	EHP/Cigna NETWORK PROVIDERS	EHP PREFERRED PROVIDERS	EHP SELECT PEDIATRIC PROVIDERS
REPRODUCTIVE HEALTH, continued			
Voluntary sterilization	100% (no deductible)	100% (no deductible)	100%
Interruption of pregnancy	80% after deductible	90% after deductible	100%
Infertility treatment	Not covered	90% after annual deductible, plus a separate $1,000 lifetime deductible (2)	Not available
9. URGENT CARE CENTER			
Urgent care visit	100% after $40 copay (no deductible)	100% after $40 copay (no deductible)	Not available
Diagnostic services and treatment	100% (no deductible)	100% (no deductible)	Not available
10. EMERGENCY CARE			
Care in emergency department for emergency medical conditions only (1)	100% after $250 copay and deductible (copay waived if admitted)	100% after $250 copay and deductible (copay waived if admitted)	100% after $250 copay (waived if admitted)
11. AMBULANCE TRANSPORTATION			
Ground or air transportation when medically necessary (1); prior authorization required for air ambulance in non-emergencies	90% after deductible	90% after deductible	Not available
12. HOSPITAL CARE			
Inpatient facility charges (semi-private, unless private room is medically necessary); prior authorization required	$250 copay per admission, then 80% after deductible	$250 copay per admission, then 90% after deductible	100%
Inpatient professional fees (excluding surgical)	80% after deductible	90% after deductible	100%
Skilled nursing/rehabilitation facility charges; 120 days per calendar year combined maximum; prior authorization required	90% for first 30 days per year, then 80% for remaining days after deductible	90% after deductible	100%

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

Only medically necessary services and supplies are covered. Because medical treatments are constantly changing, Johns Hopkins EHP and Cigna can determine that prior authorization is required for additional services and supplies not shown in this chart.

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

(2) Only covered at Johns Hopkins and Shady Grove Fertility Centers, Florida Fertility Institute and The Reproductive Medicine Group. Lifetime dollar and attempt maximums apply. Prior authorization required for certain services.

MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP/Cigna NETWORK PROVIDERS	EHP PREFERRED PROVIDERS	EHP SELECT PEDIATRIC PROVIDERS
HOSPITAL CARE, continued			
Outpatient professional fees, including testing prior to surgery	80% after deductible 85% after deductible at ambulatory surgery center	90% after deductible 95% after deductible at ambulatory surgery center	100%
Outpatient surgery facility charges	80% after deductible 85% after deductible at ambulatory surgery center	90% after deductible 95% after deductible at ambulatory surgery center	100%
Observation care facility charges	100% after $250 copay and deductible (copay waived if admitted)	100% after $250 copay and deductible (copay waived if admitted)	100% after $250 copay (waived if admitted)
Observation care professional fees	100% after deductible	100% after deductible	100%
13. CHEMOTHERAPY/ RADIATION THERAPY			
Providers fees	80% after deductible	90% after deductible	100%
Materials and treatment	80% after deductible	90% after deductible	100%
14. ACUPUNCTURE			
For anesthesia, pain control and therapeutic purposes; 20 visit per calendar year combined maximum	80% after deductible	90% after deductible	Not available
15. HOME HEALTH CARE			
180 visits per calendar year combined maximum	80% after deductible	90% after deductible	100%
16. HOSPICE CARE			
Inpatient and home	100% after deductible	100% after deductible	Not available
17. SPEECH THERAPY			
	80% after deductible	90% after deductible	100%
18. PHYSICAL/OCCUPATIONAL THERAPY			
Licensed therapist only	80% after deductible	90% after deductible	100%
19. HABILITATION SERVICES			
Under age 19 only	80% after deductible	90% after deductible	100%

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

Only medically necessary services and supplies are covered.

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

MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP/Cigna NETWORK PROVIDERS	EHP PREFERRED PROVIDERS	EHP SELECT PEDIATRIC PROVIDERS
20. CHIROPRACTIC CARE			
Restricted to initial exam, X-rays and spinal manipulations; 20 visit per calendar year combined maximum	80% after deductible	90% after deductible	Not available
21. DURABLE MEDICAL EQUIPMENT AND SUPPLIES			
Non-custom equipment and medical supplies	80% after deductible	90% after deductible, thru Johns Hopkins Care at Home	100%
Custom equipment/wheelchairs; prior authorization required	90% after deductible	90% after deductible	100%
Insulin pumps, continuous glucose monitors and related supplies	90% after deductible	90% after deductible	100%
Breast pumps (standard) and related supplies	100% (no deductible)	100% (no deductible) thru Johns Hopkins Care at Home	100%
Custom molded orthotics	80% after deductible	90% after deductible	100%
Prosthetic devices; prior authorization required	90% after deductible	90% after deductible	100%
Hearing aids for children under 26	90% after deductible	90% after deductible	100%
Blood pressure cuffs	80% (no deductible)	90% (no deductible)	100%
22. NUTRITION COUNSELING			
	80% after deductible	90% after deductible	100%
23. DIALYSIS			
	80% after deductible	90% after deductible at Fresenius/Davita Dialysis Centers	100%
24. HYPERBARIC OXYGEN THERAPY			
Prior authorization required	80% after deductible	90% after deductible	100%

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

Only medically necessary services and supplies are covered.

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

MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP/Cigna NETWORK PROVIDERS	EHP PREFERRED PROVIDERS	EHP SELECT PEDIATRIC PROVIDERS
25. CARDIAC AND PULMONARY THERAPY			
	80% after deductible	90% after deductible	100%
26. INFUSION THERAPY			
Home infusion therapy	80% after deductible	90% after deductible, thru Johns Hopkins Care at Home	100%
Outpatient infusion therapy	80% after deductible	90% after deductible	100%
27. INJECTIONS			
Injections, materials and serum	80% after deductible	90% after deductible	100%
28. TELEMEDICINE			
Johns Hopkins OnDemand Virtual Care	Not applicable	100% (no deductible)	Not available
Medical advice messaging	100% after $5 copay (no deductible)	100% after $5 copay (no deductible)	$5 copay
All other virtual care	See specific covered benefit section	See specific covered benefit section	100%
29. MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT			
Inpatient care facility charges; prior authorization required	80% after $250 copay per admission and deductible	90% after $250 copay per admission and deductible	100%
Inpatient care professional fees	80% after deductible	90% after deductible	100%
Outpatient care facility charges	100% after $20 copay per visit (no deductible)	100% after $20 copay per visit (no deductible)	100%
Outpatient care professional fees	100% after $20 copay per visit (no deductible)	100% after $20 copay per visit (no deductible)	100%
Biofeedback	80% after deductible	90% after deductible	100%
Partial hospital facility and Intensive Outpatient Program days	100% after $20 copay per day (no deductible)	100% after $20 copay per day (no deductible)	100%
Medication management	100% after $20 copay per visit (no deductible)	100% after $20 copay per visit (no deductible)	100%
Mental health testing and procedures	100% after $20 copay per visit (no deductible)	100% after $20 copay per visit (no deductible)	100%
Methadone treatment	100% after $20 copay per visit (no deductible)	100% after $20 copay per visit (no deductible)	100%

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

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

30. PRESCRIPTION DRUGS			
In-network pharmacy only; 30-day supply; No copay for certain generic contraceptives	Up to $10 copay – generic (Tier 1) 25% coinsurance ($40 min/$60 max) – brand preferred (Tier 2) 50% coinsurance ($65 min/$105 max) – brand non-preferred (Tier 3) 50% coinsurance ($65 min/$105 max) – brand if generic available, plus cost difference (Tier 4)		
In-network pharmacy only; 30-day supply for these prescribed generic Over-the-Counter drugs	Up to $10 copay – prescribed OTC generic equivalents of Prilosec, Nexium, Prevacid and Zegerid No copay for prescribed OTC generic equivalents of Claritin, Claritin D, Allegra, Allegra D, Zyrtec or Zyrtec D Must have prescription and present it to the pharmacy		
90-day supply for maintenance drugs (excludes specialty medications). Mail order or In-network pharmacy. No copay for certain generic contraceptives	Up to $30 copay – generic (Tier 1) 25% coinsurance ($120 min/$180 max) – brand preferred (Tier 2) 50% coinsurance ($195 min/$315 max) – brand non-preferred (Tier 3) 50% coinsurance ($195 min/$315 max)– brand if generic available, plus cost difference (Tier 4)		
Specialty medications **covered** by PrudentRx Program; 30-day supply; Only covered at Johns Hopkins Outpatient Pharmacies and CVS Specialty Pharmacy	No copay when obtained through PrudentRx Program 30% coinsurance with no maximum if not obtained through PrudentRx Program		
Specialty medications **not** covered by PrudentRx Program; 30-day supply; Covered at any In-network pharmacy	Up to $10 copay – generic (Tier 1) 25% coinsurance ($40 min/$60 max) – brand preferred (Tier 2) 50% coinsurance ($65 min/$105 max) – brand non-preferred (Tier 3) 50% coinsurance ($65 min/$105 max) – brand if generic available, plus cost difference (Tier 4)		

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

Only medically necessary services and supplies are covered.

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

Covered Services and Supplies

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

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

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

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

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

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

Ambulance Services

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

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

- ♦ You are admitted to an Out-of-Network hospital from the emergency department, your condition stabilizes so that it is no longer an **emergency medical condition**, and you wish to be moved to an EHP Network facility, or
- ♦ With prior authorization by EHP Utilization Management or Cigna based on special medical circumstances

Air ambulance is covered only if it is medically necessary to be transported by air and not by ground. It is not medically necessary to be transported by air if a facility that can provide the necessary medical care can be safely accessed by ground transportation. *Except for an **emergency medical condition**, air ambulance transportation must receive prior authorization and must be provided by an EHP/Cigna PPO Network air ambulance provider, or it will not be covered.*

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

Air Ambulance Transportation by Out-of-Network Provider

Charges for transportation by an Out-of-Network air ambulance provider for an **emergency medical condition** are covered as though you received transportation by an EHP/Cigna PPO Network air ambulance provider. This means:

- The same cost sharing requirements (deductible and coinsurance) apply to the Out-of-Network air ambulance transportation charges as would apply to EHP/Cigna PPO Network air ambulance charges for the same transportation. Your cost sharing payments will be based on the **qualifying payment amount**, not the amount charged by the Out-of-Network provider. **Qualifying payment amount** means the charges for Out-of-Network air ambulance transportation that are recognized by the EHP Medical Plan in accordance with regulations issued under ERISA Section 717.

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

Emergency Care

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

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

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

Emergency Department

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

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

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

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

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

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

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

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

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

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

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

Urgent Care Center

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

If you go to an EHP/Cigna PPO Network urgent care center, your care will be covered at 100% with no deductible, after a $40 copay.

The Plan does not cover any charges if you go to an Out-of-Network urgent care center.

Gender Affirmation

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

Coverage is provided only for members who have a diagnosis of gender dysphoria in accordance with the Johns Hopkins Health Plans Medical Policy for Gender Affirming Treatment & Procedures. Gender affirmation therapy (including hormone therapy and psychotherapy) and surgical procedures (and complications therefrom) are covered only to the extent the member meets the criteria for a determination that the therapy or procedure is medically necessary as set forth in the Policy.

Procedures that are determined to be cosmetic and not medically necessary under the Policy are not covered.

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

Habilitation Services

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

Adaptive behavior treatment, such as Applied Behavior Analysis, is covered if medically necessary for the treatment of a person under age 19 with autism or autism spectrum disorder. Services must be provided by a licensed and appropriately qualified provider, such as a board certified behavior analyst.

Home Health Care

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

Home health care services and supplies must be provided by a licensed health care organization to be covered. No benefits are paid for services performed by a close relative or anyone living in your household. Each home health care visit is limited to four hours. Up to 180 home health care visits per calendar year are covered.

Covered home health care services include:

- Part-time or intermittent skilled nursing care by a nurse
- Part-time or intermittent home health aide services for a patient who is receiving covered nursing or therapy services
- Physical, respiratory, occupational and speech therapy when provided by a home health care agency

- Medical and surgical supplies when provided by a home health care agency (excluding non-injectable prescription drugs)
- Injectable prescription drugs (subject to copay as described under **Prescription Drug Benefits**)
- Oxygen and its administration
- Medical and social service consultations

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

- Domestic or housekeeping services
- Rental or purchase of equipment or supplies
- Meals-on-wheels or other similar food arrangements
- Care provided in a nursing home or skilled nursing/rehabilitation facility (see ***Skilled Nursing/Rehabilitation Facility Care*** below)
- More than 180 visits per calendar year
- Home care for mental health conditions
- Custodial care

Hospice Care

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

Covered hospice care services include:

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

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

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

Infertility Treatment

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

In all cases:

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

- Infertility must not be related to a previous sterilization by you or your spouse.
- No coverage is provided for surrogate motherhood or gestational carrier purposes. This exclusion does not apply to charges for treatment of the newborn child if the child is a covered eligible dependent of the member.

For married opposite sex couples:

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

For single females:

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

For married female same sex couples:

- The birth mother's egg must be used, unless there is a documented medical condition unrelated to age whereby use of the birth mother's egg is not possible.

For married male same sex couples:

- Infertility treatment is not provided for married male same sex couples.

Injectable Drugs

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

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

Maternity Care

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

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

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

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

Medical and Modified Foods

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

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

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

- Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins;

- severe food protein induced enterocolitis syndrome,
- eosinophilic disorders, as evidenced by the results of a biopsy, or
- impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Obesity Treatment

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

- Non-surgical treatment including management by a primary care provider and counseling by a nutritionist. Also see the Health and Wellness Programs section earlier in this SPD for information on the Plan's free health education programs.

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

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

Physical, Occupational and Speech Therapy -- Outpatient

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

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

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

Skilled Nursing/Rehabilitation Facility Care

Your stay in a skilled nursing/rehabilitation facility must receive prior authorization.

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

Covered skilled nursing/rehabilitation facility services include:

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

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

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

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

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

Telemedicine

Video, audio and telephone

The EHP Medical Plan covers telemedicine visits (video, audio and telephone) with your health care provider. Telemedicine visits are covered on the same terms and are subject to the same requirements as in-person visits. Telemedicine visits by Out-of-Network providers are not covered.

You can also use Johns Hopkins OnDemand Virtual Care. This service allows you to connect with a provider for a general medical visit 24/7 from the comfort of your home or anywhere you may travel in the United States. This service can be used as an alternative if you are unable to see your PCP. Use of this service is intended for common, minor ailments, such as a cough, rash, seasonal allergies, cold and flu symptoms, pink eye, sinus infection, sore throat, and more. This service is not for medical emergencies.

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

Medical advice messaging

If you access medical advice messaging with an EHP/Cigna PPO Network or EHP Select Pediatric provider, you only pay a $5 copay and no Deductible for covered billed charges.

Transplants

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

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

- Inpatient or outpatient hospital charges for treatment and surgery by a Johns Hopkins Employer Health Programs designated transplant center
- Tissue typing
- Removal of the organ
- Obtaining, storing, and transporting the organ
- Travel expenses to and from the transplant center as described next under ***Travel Reimbursement***

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

- Organ transplant charges incurred without prior authorization, or at a transplant center that was not designated by Johns Hopkins Employer Health Programs
- The transplant of an organ which is synthetic, artificial, or obtained from other than a human body
- An organ transplant or organ procurement performed outside the United States
- An organ transplant that the Plan Administrator determines to be experimental

- ♦ Expenses of an organ donor, except when the recipient is a participant in this Plan who receives the organ in a covered organ transplant. When coordinating with the donor's health plan, the EHP Medical Plan will be secondary. If an organ is sold (i.e., not donated), no benefits are paid for the donor's expenses.

Travel Reimbursement

The EHP Medical Plan will reimburse you for eligible expenses incurred when it is necessary to travel to receive medical treatment as follows:

- The medical treatment the patient receives must be covered by the Medical Plan
- There must be no EHP/Cigna Network or EHP Select Pediatric provider facility that can provide the medical treatment located within 50 miles of the patient's home address
- After the medical deductible is met, eligible travel expenses are covered at 100% up to a maximum reimbursement of $150 per day for the patient and a companion combined
- The maximum reimbursement for any course of treatment is $10,000
- Travel expenses are not eligible for reimbursement unless an overnight stay is involved
- The maximum reimbursement for lodging expenses is $50 per night
- Expenses of a companion are only eligible if the companion is at least 18 years old and is the patient's spouse, parent, legal guardian, brother, sister, child or dependent for tax purposes
- Receipts are required for all expenses except mileage

All reimbursements are subject to the requirements of the Johns Hopkins Health Plans Medical Travel Reimbursement Policy. Before you or a family member travel to receive medical treatment, you should contact EHP Customer Service and ask for a copy of the Medical Travel Reimbursement Policy.

Other Services and Supplies

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

- ♦ Abortion

- ♦ Acne and actinic keratosis procedures *(prior authorization required)*

- ♦ Acupuncture for anesthesia, pain control and therapeutic purposes, when provided by a licensed acupuncturist

- Adaptive behavior treatment for autism -- see ***Habilitation Services*** above
- Anesthetics and administration
- Back pain invasive treatment such as facet blocks and radiofrequency ablation *(prior authorization required)*
- Biofeedback therapy
- Blood products
- Botox Type A and B *(prior authorization required)*
- Calcium scoring/electron beam computer tomography
- Capsule endoscopy *(prior authorization required)*
- Cardiac rehabilitation
- Casts
- Chiropractic care for misalignment or partial dislocation of or in the vertebral column and correction by manual or mechanical means of nerve interference
- Contraceptive devices provided for in comprehensive guidelines supported by the Health Resources and Services Administration and approved by the Food and Drug Administration
- Cosmetic/reconstructive surgery when due to:
  - accidental injury or illness that is or would be covered by the Plan, or
  - correction of a congenital malformation of a child, including cleft lip and cleft palate
- Cosmetic/reconstructive surgery when due to a mastectomy, including:
  - reconstruction of the breast on which the mastectomy was performed,
  - surgery and reconstruction of the other breast to provide a symmetrical appearance,
  - prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes), and
  - 3-D nipple tattooing of a reconstructed breast, but only if the tattoo artist is recommended by the provider of the reconstructive surgery, and possesses a license to provide tattoos if a license is required.

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

- Diabetic supplies

- Dialysis

- Durable medical equipment, including wheelchairs *(prior authorization required for some equipment)*. Durable medical equipment is medical equipment which:

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

- Elastography *(prior authorization required)*

- Electroretinography *(prior authorization required)*

- External beam radiation therapy *(prior authorization required)*

- Feeding programs *(prior authorization required)*

- Foot care for incision and drainage of infected tissues of the foot, removal of lesions, treatment of fractures and dislocations of bone in the foot

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

- Genetic testing *(prior authorization required)*

- GERD (gastroesophageal reflux disease) devices *(prior authorization required)*

- Hearing aids for a dependent child under age 26, up to $1,400 per aid. The aids must be prescribed, fitted, and dispensed by a licensed audiologist. Replacement aids are available only once every three years.

- Hearing devices that are implanted

- Hospital charges for covered semi-private room and board and other hospital-provided services and supplies *(prior authorization required)*

- Hyperbaric oxygen therapy *(prior authorization required)*
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Injectable drugs provided in a physician's office – see ***Injectable Drugs*** above
- Laboratory tests
- Laser treatment for skin conditions *(prior authorization required)*
- Light box therapy *(prior authorization required)*
- Long term cardiac event monitoring (Zio Patch) *(prior authorization required)*
- Midwifery services – see ***Maternity Care*** above
- Neuropsychiatric testing
- Neurostimulators *(prior authorization required)*
- Newborn care
- Nicotine addiction treatment or smoking cessation programs, as covered by United States Preventive Services Task Force preventive care recommendations with a rating of A or B. Prescription and OTC tobacco cessation products (including Chantix) are covered, limited to FDA approved dosages. A prescription from a physician is required for coverage of OTC products. No copay applies to most prescribed tobacco cessation medications.
- Nursing services (professional) by a registered nurse or licensed practical nurse who is not a close relative (spouse, child, grandchild, brother, sister, brother-in-law, sister-in-law, parent, or grandparent) of the patient
- Nutrition counseling
- Observation care *(prior authorization required after 24 hours)*

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

- Osteogenic Stimulation for fractures *(prior authorization required)*

- Oxygen and its delivery

- Palliative care *(prior authorization required)*

- Pharmacogenomics genotyping *(prior authorization required)*

- Preventive care for adults, children and adolescents, including evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force

- Proton beam radiotherapy *(prior authorization required)*

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

- Pulmonary therapy

- Pulse oximetry at home *(prior authorization required)*

- PUVA phototherapy *(prior authorization required)*

- Radiology:

    - CT Scan
    - Diagnostic X-ray
    - MRI
    - PET scan
    - Prenatal ultrasound

- Sclerotherapy *(prior authorization required)*

- Splints

- Specialist consultation services. Staff consultation required by the facility is not covered.

- Surgical procedures and second opinions. *Prior authorization required for certain procedures, as set forth on a list maintained by Johns Hopkins Employer Health Programs.*

- Temporomandibular Joint Syndrome (TMJ) treatment and/or orthognathic surgery, limited to physical therapy, surgery and ortho devices such as mouthguards and intraoral devices (excludes orthodontics and prosthetics) *(prior authorization required)*

- Testing and treatment required to be covered by the Families First Coronavirus Response Act

- Vasectomies and tubal ligations

- Well-child care, including evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration

- Well-woman care, including evidence-informed preventive care and screenings for women provided for in comprehensive guidelines supported by the Health Resources and Services Administration

- Wigs in the case of baldness resulting from chemotherapy, radiation therapy or surgery, in which case benefits are limited to one wig once every 24 months, not to exceed $400

- Wound clinic *(prior authorization required after 10 visits)*

- Wound vac

- X-ray, radium, and radioisotope treatment

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

Mental Health and Substance Use Disorder Treatment

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

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

Like any other medical or surgical treatment, any inpatient admission (including inpatient residential treatment centers) must receive prior authorization.

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

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

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

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

Prescription Drug Benefits

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

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

EHP Network Pharmacies

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

When you buy covered drugs from an EHP Network pharmacy, present your EHP Medical Plan identification card to the pharmacist. You should request and retain a paid receipt for your copay/coinsurance amount if you need it for income tax purposes or to submit a claim to your health care flexible spending account.

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

Copay and Coinsurance

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

For up to a 30-day supply of brand name preferred drugs (Tier 2), you pay 25% coinsurance, subject to a $40 minimum and $60 maximum payment. For up to a 30-day supply of brand name non-preferred drugs (Tier 3), you pay 50% coinsurance, subject to a $65 minimum and $105 maximum payment. For up to a 30-day supply of brand name drugs if a generic equivalent is available (Tier 4), you pay 50% coinsurance, subject to a $65 minimum and $105 maximum payment, plus the difference in cost between the generic and the brand name drug. (In no event would you have to pay more than the full cost of the brand name drug itself.)

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

For brand name preferred specialty medications you pay 25% coinsurance, subject to a $40 minimum and $60 maximum payment. For brand name non-preferred specialty medications you pay 50% coinsurance, subject to a $65 minimum and $105 maximum payment. Specialty medications are only covered for up to a 30-day supply. Specialty medications include, but are not limited to, biologic medications and medications that are injected or infused. **See the PrudentRx Program discussion below for additional rules for specialty medications.**

For maintenance drugs (excluding specialty medications), you may obtain a 90-day supply at an In-Network retail pharmacy or you may use the EHP Medical Plan's Mail Order program, presently offered through CVS Caremark. For generic drugs a $30 copay applies. For brand name drugs the same coinsurance percentage (25% or 50%) is charged as for a 30 day supply, subject to three times the applicable minimum/maximum charge. If you obtain a brand name drug when a generic equivalent is available, then unless you receive prior authorization as explained above you must also pay the difference in cost between the generic and the brand name drug.

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

Annual copays and coinsurance amounts are subject to the Prescription Drug out-of-pocket maximum shown in the **Medical Benefits-At-A-Glance** chart earlier in this SPD. If you obtain a specialty medication without going through the PrudentRx Program described next, you must pay 30% coinsurance with no out-of-pocket maximum.

PrudentRx Program for Specialty Medications

The PrudentRx Program helps you enroll in drug manufacturer copay/coinsurance assistance programs for specialty medications on the Specialty Drug List, which can be viewed at www.ehp.org. Go to the Benefits & Coverage Overview page, enter your employer and plan information, click on "Prescription Benefits", then click on "Pharmacy Overview" and scroll down to "PrudentRx Program" to view the PrudentRx Specialty Drug List. The Specialty Drug List is subject to change and is updated frequently.

Copay/coinsurance assistance is a process by which drug manufacturers cover most or all of a patient's copay/coinsurance requirement for certain specialty medications. The PrudentRx Program will help you obtain copay/coinsurance assistance from drug manufacturers for the specialty medication you take.

If you obtain a specialty medication on the Specialty Drug List through the PrudentRx Program, you pay no coinsurance and no copay for the medication.

However, you pay 30% coinsurance with no out-of-pocket maximum for each prescription or refill of a specialty medication on the Specialty Drug List, if you do not obtain the medication through the PrudentRx Program.

Specialty medications on the Specialty Drug List are only covered when obtained from a Johns Hopkins Outpatient Pharmacy or the CVS Specialty Pharmacy. Specialty medications on the Specialty Drug List that are obtained from any other pharmacy, even if it is an EHP Network Pharmacy, are *not* covered.

When you fill a prescription for a specialty medication on the Specialty Drug List at a Johns Hopkins Outpatient Pharmacy or the CVS Specialty Pharmacy, you will be contacted by PrudentRx, which will help you enroll in any available manufacturer copay/coinsurance assistance programs. **If you do not obtain a specialty medication on the Specialty Drug List through the PrudentRx Program, or if you drop out of or do not comply with the PrudentRx Program or manufacturer rules, you must pay 30% coinsurance for your specialty medication.**

If you have any questions, PrudentRx can be reached at 800-578-4403.

Medication Copay/Coinsurance Waiver Program

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

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

Not all drugs for treatment of asthma, diabetes, COPD, hypertension or cholesterol management are eligible for copay/coinsurance waiver, but many of the most widely prescribed drugs are. The Frequently Asked Questions piece contains a list of the drugs that are currently eligible.

Prior Authorization, Quantity Limits and Step Therapy

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

You can find out if a drug is subject to Prior Authorization, Quantity Limits and Step Therapy by going to the EHP website at www.ehp.org. Go to the Benefits & Coverage/Overview page, enter your employer and plan information, click on “Prescription Benefits”, then click on “Pharmacy Overview” and scroll down to “Prior Authorization”, “Quantity Limits” or “Step Therapy” and follow the instructions. Call EHP Customer Service at 410-424-4450 or 800-261-2393 if you need assistance.

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

Caremark Formulary Drugs

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

If a drug is not listed on the Formulary, you must pay the full cost for the drug unless Caremark issues a prior authorization for medical necessity for the drug. Caremark will only do so if your physician can demonstrate that it is medically necessary for you to take the non-Formulary drug instead of the other optional drugs that are listed on the Formulary. To request prior authorization for medical necessity for a non-Formulary drug, your physician must complete the CVS Caremark Electronic Prior Authorization process or call CVS Caremark. The link for the electronic process and the phone number are available on the Johns Hopkins Health Plans provider website. If Caremark grants the request for prior authorization for a non-Formulary drug, you must pay the copay that applies to brand name non-preferred drugs. If Caremark denies the request for prior authorization for a non-Formulary drug, you or your physician can make a First Level Appeal to Caremark in accordance with the directions included on the denial letter. If Caremark denies the First Level Appeal, you may make a Final Appeal to the Appeal Fiduciary in accordance with the appeal rules for pre-service claims set forth later in this SPD under Claims and Appeals.

What’s Not Covered

No prescription drug benefits will be paid for the following:

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

Over-the-Counter Drugs

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

- Generic non-sedating antihistamines such as OTC Loratadine and Loratadine D (generic equivalents of Claritin/Claritin D), OTC Fexofenadine/Fexofenadine D (generic equivalents of

Allegra/Allegra D) and OTC Cetirizine/Cetirizine D (generic equivalents of Zyrtec/Zyrtec D) – no copay

- Generic proton pump inhibitors such as OTC Omeprazole (generic equivalent of Prilosec), OTC Esomeprazole (generic equivalent of Nexium), OTC Lansoprazole (generic equivalent of Prevacid), and OTC Omeprazole/Sodium Bicarbonate (generic equivalent of Zegerid) – $10 copay per 30-day supply

Preventive Care Drugs

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

What's Not Covered by The EHP Medical Plan

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

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

- Doula services

- Drugs or devices not approved by the FDA for marketing and/or for the prescribed treatment of a specific diagnosis unless approved by Utilization Management. This exclusion does not apply to a medical device to the extent Medicare would cover the device in accordance with Medicare Policy Manual Chapter 14

- Emergency department services for other than an emergency medical condition

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

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

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

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

to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

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

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

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

WHAT'S NOT COVERED

- Glasses, contact lenses, eye refractions, or the examinations for their fitting or prescription, except when medically necessary after cataract surgery

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

- Hearing aids, or the examination for their fitting or prescription (except for dependent children as described under ***Other Services and Supplies*** earlier in this SPD)

- Hypnosis

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

- Injury sustained or an illness contracted while committing a crime, including but not limited to operating a motor vehicle, boat or watercraft while under the influence of alcohol or drugs

- Injury sustained or an illness resulting from war, act of war, act of terrorism, riot, rebellion, civil disobedience, or from military service in any country

- Injury sustained while riding on a motorcycle, unless the covered person was wearing a helmet that meets applicable safety standards issued by the National Highway Traffic Safety Administration. This exclusion applies even when riding in a state that does not require wearing a helmet.

- Marital counseling

- Missed appointment charges

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

- Nicotine addiction treatment or smoking cessation programs, except as covered by United States Preventive Services Task Force preventive care recommendations with a rating of A or B

- Obesity treatment, including surgical procedures for weight reduction or for treatment of conditions resulting from being overweight, except as described under ***Obesity Treatment*** earlier in this SPD

- Private duty nursing

WHAT'S NOT COVERED

- Private room charges beyond the amount normally charged for a semi-private room, unless a private room is medically necessary

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

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

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

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

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

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

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

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

- Services and supplies required as a condition of employment

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

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

- Sexual dysfunction treatment not related to organic disease

- Support garments

- Surgical treatment for overhanging, stretching or laxity of skin, except as described under ***Obesity Treatment*** earlier in this SPD
- Surrogate motherhood or gestational carrier treatment, including any charges related to giving birth or for treatment of the newborn child resulting from the surrogate motherhood or gestational carrying. This exclusion does not apply to charges for treatment of the newborn child if the child is a covered eligible dependent of the member.
- Telephone consultation charges, unless covered as described under ***Telemedicine*** earlier in this SPD
- Treatment which is not medically necessary, as described under **Covered Services and Supplies** earlier in this SPD
- Treatment which is not performed by an appropriate licensed professional provider acting within the scope of the provider's license
- Treatment for:
  - an injury arising out of, or in the course of, any employment (including self-employment) for wage or profit, or
  - a disease covered with respect to your employment, by any Workers' Compensation law, occupational disease law, or similar legislation
- Treatment covered by no-fault auto insurance, or any other federal or state-mandated law
- Treatment for which a third party may be liable, unless otherwise payable as described under **Reimbursement and Subrogation,** later in this SPD
- Treatment by a provider who is a close relative of the patient (spouse, child, grandchild, brother, sister, brother in law, sister in law, parent or grandparent) or who resides in the patient's home
- Vision therapy/training or eye exercises to increase or enhance visual activity or coordination
- Wigs and artificial hair pieces, except in cases of baldness resulting from chemotherapy, radiation therapy or surgery, in which case benefits are limited to one wig once every 24 months, not to exceed $400

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

Administrative Information About Your Benefits

Filing A Claim With Employer Health Programs

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

You do need to file a claim form with Employer Health Programs if you receive services from an Out-of-Network provider that is covered as explained under ***Special Rules for Certain Treatment by Out-of-Network Providers***, ***Ambulance Services***, ***Air Ambulance Transportation*** and ***Emergency Care*** earlier in this SPD and ***Care Received Outside the United States*** later in this SPD, unless the Out-of-Network provider files the claim for you. It is your responsibility to determine if the Out-of-Network provider files a claim for you.

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

Itemized bills must include the following information:

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

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

Coordination of Benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Coverage Under Other EHP Medical Plans

Benefits provided by any prior version of the EHP Medical Plan are treated as benefits provided under this EHP Medical Plan when applying lifetime limits. Benefits provided under the Exclusive Provider Organization, Preferred Provider Organization and Direct Primary Care versions of the EHP Medical Plan are aggregated with each other when applying lifetime limits.

Transferring Employment Within the Health System

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

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

Care Received Outside the United States

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

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

Claims for ***foreseeable*** medical care received or for ***foreseeable*** prescription drugs obtained while outside the United States are not covered.

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

Employees Whose Worksite Is Outside The United States

Employees whose worksite is outside the United States do not have coverage under the EHP Medical Plan. Instead, an insurance policy (currently issued by MetLife) provides the health insurance coverage.

Reimbursement and Subrogation

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

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

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

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

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

Your obligations

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

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

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

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

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

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

Reimbursement

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

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

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

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

In order to secure the Plan's reimbursement rights, you, to the full extent of the Plan's claim for reimbursement, (1) grant the Plan a first priority lien against the proceeds of any Recovery received and against any party who is in possession of funds that may ultimately be used for your Recovery; (2) assign to the Plan any benefits you may have under any insurance policy or other coverage and (3) agree to hold in constructive trust as a fiduciary for the Plan the proceeds of any Recovery received. Failure to hold such proceeds in trust will be deemed a breach of your fiduciary duties to the Plan. By paying, or being obligated to pay, any claims to you or on your behalf, the Plan automatically has the lien and other rights described in this section.

Subrogation

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

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

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

The Plan's rights

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

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

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

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

Workers Compensation Recovery

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

The recovery rights can be applied even though:

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

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

Benefits Paid by Mistake

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

When Benefit Plan Coverage Ends

Your coverage under the EHP 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. You will be considered an employee who is eligible for benefits so long as you are eligible under the terms of your employer’s leave of absence policy, or so long as you are receiving short term disability benefits from your employer;
- ♦ If you are eligible under the Special Eligibility Rules for "ACA Full-Time Employees", the end of the Stability Period for which you are an ACA Full-Time Employee, unless you continue to be an ACA Full-Time Employee for the following Stability Period or you become eligible under the Regular Eligibility rules;
- ♦ The end of the month preceding the effective date of your waiver of coverage under the plan;
- ♦ The end of the month for which you last make the required contributions for coverage;
- ♦ The date the plan is discontinued;
- ♦ The date on which you report for active duty as a full-time member of the armed forces of any country.

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

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

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

COBRA Continuation Coverage

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

Length of COBRA Coverage

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

- ♦ Your employment ends for reasons other than gross misconduct;
- ♦ Your work hours are reduced so that you are no longer eligible; or
- ♦ Your eligibility for coverage terminates at the end of a Stability Period, as explained in the **Special Eligibility Rules** discussion under **Who Is Eligible** earlier in this SPD.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Electing COBRA Coverage

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

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

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

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

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

When COBRA Coverage Ends

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

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

Benefit Coverage During Family and Medical Leave (FML)

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

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

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

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

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

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

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

Approved Medical and Dependent Care Leaves

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

If you return to employment with All Children's at the end of your non-FML Medical or Dependent Care leave, and if you timely paid your required employee contributions during the leave, the benefit plan coverage you had in effect before the leave began will continue. If your benefit plan coverage terminated during the leave for failure to pay contributions, coverage will not resume after you return to employment, unless and until you again elect coverage either during open enrollment or as explained earlier in this SPD under Changing Your Coverage.

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

Other Approved Leaves

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

When You Become Covered By Medicare

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

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

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

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

Medicare and End Stage Renal Disease

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

Non-Discrimination in Benefits

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

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

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

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

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

- Provides free aids and services to people with disabilities to communicate effectively with EHP, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

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

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

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

Plan Information

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

Plan Sponsor

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

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

Plan Administrator

ADMINISTRATIVE INFORMATION

The Plan Administrator manages the Employee Benefits Plan on a day-to-day basis and resolves questions about Plan details and entitlement to benefits. The Plan Administrator is the Johns Hopkins Hospital, 1800 Orleans Street, Baltimore, MD, 21287, telephone 443-997-5400.

If you have questions about your benefits and how they are administered, you should contact the HR Support Center.

Plan Year

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

Plan Funding

The EHP Medical Plan is not financed or administered by an insurance company. Benefits are paid from the general assets of All Children's through contracts with Johns Hopkins Employer Health Programs. You can contact Johns Hopkins Employer Health Programs at:

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

Plan Number

The plan number is 506.

Legal Action

The agent for service of legal process is:

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

You may also serve legal process on the Plan Administrator.

Prohibition On Assignment Of Benefits

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

Claims And Appeals

In order for you to receive Medical benefits, you or your provider must file a claim. Claims are filed for you by EHP/Cigna PPO Network and EHP Select Pediatric providers. You must file claims for Out-of-Network care that is covered as explained under ***Special Rules for Certain Treatment by Out-of-Network Providers***, ***Ambulance Services***, ***Air Ambulance Transportation***, ***Emergency Care*** and ***Care Received Outside the United States*** earlier in this SPD.

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

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

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

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

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

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

As indicated throughout this SPD, certain services and supplies must receive prior authorization by EHP Utilization Management (for EHP Network and EHP Select Pediatric providers) or by Cigna (for

Cigna PPO Network providers) in order to be covered. If a service or supply must receive prior authorization, a request for prior authorization is a **"Pre-Service Claim"**.

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

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

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

If a service or supply does not need to receive prior authorization, a claim for payment is a **"Post-Service Claim"**.

Filing a Claim

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

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

All Children's
EHP Medical Plan
c/o Johns Hopkins Employer Health Programs
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Itemized bills must include the following information:

- the date(s) the services, drugs or supplies were received;

- ♦ the diagnosis;
- ♦ a description of the treatment received;
- ♦ the charge for each service, drug or supply;
- ♦ the name, address and professional status of the provider; and
- ♦ the full name of the patient.

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

Reducing, Terminating or Extending an Approved Course of Treatment

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

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

Authorized Representative

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

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

Claims for Children

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

Claims and Appeals Procedures

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

Urgent Care Claims

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

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

Pre-Service Claims

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

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

Post-Service Claims

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

If Additional Information is Needed

Pre-Service and Post-Service Claims

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

Urgent Care Claims

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

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

If Your Claim is Denied

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

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

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

First Level Appeal

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

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

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

Except for an appeal of a denial of an Urgent Care Claim, your First Level Appeal must be in writing and mailed to the following address:

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

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

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

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

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

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

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

If your claim for treatment in an emergency department was denied on the grounds that you did not have an emergency medical condition, your First Level Appeal may be referred to an Independent Review Organization (IRO) for determination. In that event, the IRO takes the place of the appeals department under these claims procedures, and any reference in these procedures to the appeals department should be read as a reference to the IRO.

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

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

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

When Your First Level Appeal Will Be Decided

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

> **Urgent Care Claim** -- You will be notified of the decision within 72 hours after your First Level Appeal is filed.
>
> **Pre-Service Claim** -- You will be notified of the decision within 15 days after your First Level Appeal is filed.
>
> **Post-Service Claim** -- You will be notified of the decision within 30 days after your First Level Appeal is filed.
>
> **Reduction or termination of an approved course of treatment** -- You will be notified of the decision within 30 days after your appeal is filed. However, if you filed your appeal within 10 days after being notified of the proposed action, the course of treatment will not be reduced or

terminated before your appeal is decided. (See below for additional Final Appeal rights you may have before treatment is reduced or terminated.)

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

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

Final Appeal

If your First Level Appeal is denied in whole or in part, you may make a Final Appeal to the Appeal Fiduciary. The Appeal Fiduciary is the person serving as the Director of Benefits, Johns Hopkins Health System, or such other person or entity designated by the Plan Administrator to decide Final Appeals. However, if your First Level Appeal involved a refusal by Cigna to provide prior authorization for treatment, you must instead make the Final Appeal to Cigna.

When deciding Final Appeals, the Appeal Fiduciary and Cigna have the discretionary authority to interpret the terms of the benefit plans described in this SPD, to determine eligibility for and entitlement to benefits under the plans, and to decide any questions of fact which relate to entitlement to benefits under the plans.

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

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

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

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

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

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

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

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

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

Your Final Appeal will be considered by the Appeal Fiduciary or by Cigna. You may submit written comments, documents, records and other information relating to your claim. Everything you submit will be considered, regardless of whether it was submitted or considered in the initial benefit determination or your First Level Appeal. Upon written request and free of charge, you will be provided with reasonable access to and copies of all Plan documents, records and other information relevant to your claim.

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

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

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

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

Urgent Care Claim -- You will be notified of the decision within 72 hours after your Final Appeal is filed.

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

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

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

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

You will be sent a written notice of the decision on your Final Appeal. If your Final Appeal is denied, the notice will contain the same type of information as the notice of the denial of your First Level Appeal. If you disagree with the Final Appeal decision, you may bring a civil action against the Plan under ERISA Section 502.

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

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

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

External Review

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

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

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

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

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

Request for External Review

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

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

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

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

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

Preliminary Review

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

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

Referral to IRO

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

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

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

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

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

Expedited External Review

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

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

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

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

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

Protected Health Information

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

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

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

Your Rights Under ERISA

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

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

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

Additional ERISA Rights

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

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

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

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

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

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

Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210.

All Children's Rights

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

Not A Contract Of Employment

This SPD and the EHP Medical Plan do not constitute a contract of employment. You have the right to terminate your employment at any time. All Children's retains the same right regardless of any other documents or oral or written statements issued by the employer or its representatives.

Discretionary Authority

The Plan Administrator, the Appeal Fiduciary and Cigna have discretionary authority to interpret the terms of the EHP Medical Plan, to determine eligibility for and entitlement to benefits under the Plan, and to decide any questions of fact which relate to entitlement to benefits under the Plan.

For More Information

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