Your 2022 Benefits Handbook

The Johns Hopkins University ("JHU" or "the University") is proud to offer a comprehensive and competitive benefits program to our faculty and staff. Our benefits program — myChoices — reinforces JHU’s tradition of excellence and helps to attract and retain outstanding talent. The myChoices benefits program provides a variety of benefits to support your physical and financial wellbeing, as well as work life benefits to help you make the most of your professional and personal life.

This 2022 Benefits Handbook (the “Handbook”), provides a summary of the health and welfare benefits provided to eligible faculty and staff of the University effective January 1, 2022. For the plans that are subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), this Handbook, along with the supporting documents listed in the Appendix on page 148, serves as the Summary Plan Description (SPD) for those plans, and for The Johns Hopkins University Welfare Plan and The Johns Hopkins University Retiree Health Plan.

This Handbook is provided online as a “clickable” PDF. You can navigate between the major sections using the bookmarks panel. At the start of each section a one-level table of contents allows you to navigate to information within that section. A “Detailed Table of Contents” on the next page provides an additional navigation tool to help you find the information you need.
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About This Handbook

How This Handbook Is Organized

This Handbook includes separate sections that provide details of different health and welfare benefits (medical, dental, disability, etc.) as listed on the “Detailed Table of Contents” on page 2. The Handbook also provides information that applies to all or most of the benefit plans. These sections are separated from the specific plan details to minimize repetition and to keep related information together. These sections include:

- Eligibility and Enrollment, includes important details about your participation in the plans;
- Plan Administration, which provides administrative details such as plan numbers and statements of your rights, including your right to appeal, which is required by law; and
- Contacts, with a full list of contact details for all of the plans.

Every effort has been made to ensure that the information in this Handbook is complete and accurate. However, if there is an inconsistency between this SPD and any of the terms of the official plan documents, the plan documents will govern.

Right to Amend and Terminate the Plans

JHU reserves the right to amend, modify or terminate, at any time and for any reason, any or all of the welfare or component plans and programs described in these materials, including with respect to any retirees that are already enjoying retiree benefits. JHU also has the right to institute or change the level of employee contributions for any of these benefits. You will be notified of any change. For more information, see Administrative Information on page 115 of this Benefits Handbook.

The JHU Benefits Program does not create a contract or guarantee of employment between Johns Hopkins University and any individual. JHU or you may terminate the employment relationship at any time.
Benefits at a Glance

JHU offers the myChoices Program, which is a flexible approach to benefits, designed to meet the diverse needs of our colleagues. JHU provides a number of benefits automatically to eligible employees at no cost. In addition, you can elect to purchase additional optional benefits.

### Medical

- Broad medical coverage, including preventive care and prescription drug coverage
- Choice of medical options:
  - CareFirst BlueCross BlueShield Preferred Provider Organization (PPO) Plan
  - EHP Classic Point-of-Service (POS) Plan—not available to Bargaining Unit employees
  - CareFirst BlueCross Blue Shield High Deductible Health Plan (HDHP) — not available to Bargaining Unit employees
  - Kaiser Permanente Health Maintenance Organization (HMO)
  - BlueChoice HMO (closed to new faculty and staff participants)

### Onsite Health Clinics

JHU offers on-site health clinics that provide convenient access to care for eligible employees. The onsite clinics include the:

- Employee Health & Wellness Center, and
- East Baltimore and Homewood Occupational Health Services.

### Critical Illness Coverage

Opportunity for eligible employees to elect financial protection during treatment for illnesses such as cancer and Alzheimer’s disease. Three options for coverage:

- $10,000
- $15,000
- $20,000

### Accident Insurance

Ability to purchase low-cost coverage that pays benefits if involved in an accident off the job.

### Dental

- Coverage for many preventive, diagnostic, and other treatments, including orthodontia.
- Choice of two Delta Dental options
**Vision**

Optional vision coverage providing eye exams, as well as plan allowances on glasses and contact lenses.

**Health Savings Account (HSA)**

*Not available to Bargaining Unit employees.*

If you choose the HDHP medical plan, you are eligible to participate in a special tax-advantaged Health Savings Account (HSA) to help fund your out-of-pocket costs. If you earn $60,000 or less a year, JHU will contribute to your HSA. The amount of the annual contribution will depend on your pay band as follows:

- $40K or less band: $500 Single / $1,000 Family;
- $40,001-$60K band: $250 Single / $500 Family

HSA funds roll over from year to year — so you can spend them now or save them for later.

**Health Care Flexible Spending Account (FSA)**

- Eligible employees may contribute up to $2,750 a year to a Health Care Flexible Spending Account on a pre-tax basis to pay for eligible health care expenses.
- A Limited Purpose FSA is available to HDHP participants for eligible dental, vision and preventive care expenses only.
- Employees with a minimum of $30 in unused Health Care FSA contributions at the end of 2020 will automatically have up to $550 carried over to the next calendar year and these funds can be applied to eligible expenses in that year.

**Short-Term Disability (STD)**

Opportunity for eligible employees to elect coverage that pays 60% of pre-disability weekly earnings (with benefits not to exceed $2,500 a week) for up to 11 weeks, if the eligible employee is unable to work more than 14 consecutive days and the claim has been approved (eligible employees who select this coverage pay the cost of the coverage).

**Long-Term Disability (LTD)**

For eligible employees who meet the eligibility requirements and are disabled and unable to work due to an illness or injury, long-term disability (LTD) benefits generally pay 60% of your pre-disability monthly earnings to a monthly maximum benefit of $10,000. You are not considered disabled if you are able to earn 80% of your pre-disability income. (JHU provides this coverage at no cost to eligible employees.)

For the purposes of LTD coverage, “disabled” means:
Faculty and Staff

- You are “disabled” if you are continuously unable to perform the material and substantial duties of your regular occupation and not gainfully employed.

Bargaining Unit

- First 24 months: You are unable to perform the material duties of your regular occupation; or
- After 24 months: You are unable to engage in any occupation for which you are or become qualified by education, training or experience.

Basic Life Insurance

Faculty and Staff

- JHU provides $10,000 of coverage at no cost to eligible employees.
- Opportunity to elect additional coverage of one to eight times base salary, up to a maximum total (combined with the JHU-provided coverage) of $3,000,000 (if you select additional coverage, you pay the cost of that coverage and a Statement of Health will be required).

Bargaining Unit

- JHU provides coverage of 100% of base salary at no cost to eligible employees.
- Opportunity to elect additional coverage equal to one times your base annual salary, up to a maximum total (combined with JHU-provided coverage) of $2,000,000 (if you select additional coverage, you pay the cost of that coverage and a Statement of Health will be required).

Dependent Life Insurance

Faculty and Staff

Opportunity for eligible employees to elect one of two coverage options (if you select dependent coverage, you pay the cost of that coverage):

- $4,000 for spouse/ domestic partner and $2,000 per child; or
- $10,000 for spouse/ domestic partner and $5,000 per child.

Bargaining Unit

JHU provides $4,000 for spouse/ domestic partner and $2,000 per child at no cost to eligible employees.
Accidental Death & Dismemberment (AD&D)

Not available to Bargaining Unit employees.

- JHU provides $10,000 coverage at no cost to eligible employees.
- Opportunity to elect additional coverage for eligible employees of one to eight times base salary; up to a maximum total (combined with JHU-provided coverage) of $3,000,000 (eligible employees who select additional coverage pay the cost of that coverage).

Supplemental Dependent Accidental Death and Dismemberment (AD&D)

Not available to Bargaining Unit employees.

Opportunity for eligible employees to elect coverage in the amounts as follows:

- Spouse/domestic partner with no children: 60% of the employee’s base salary to a maximum of $250,000
- Spouse/domestic partner with children: 50% of the employee’s base salary to a maximum of $250,000
- Children: 20% of the employee’s base salary to a maximum of $50,000

Business Travel Accident Insurance

JHU provides you with coverage at no cost.

- For accidental death, dismemberment, coma, & paralysis, the Principal Sum maximums are:
  - Full-time and part-time professional and faculty employees, staff members, and bargaining unit employees: three times Annual Salary to a maximum of $500,000
  - Spouse: $50,000
  - Dependent Child(ren): $25,000
- For Out-Of-Country Medical Expense benefits the maximum is: $150,000 per sickness or injury.
- For Emergency Medical Evacuation and Repatriation coverage, the maximum is: 100% of covered expenses.
- For Security Evacuation coverage, the maximum is: $100,000.

Dependent Care Flexible Spending Account (FSA)

Eligible employees may contribute up to $5,000 a year on a pre-tax basis to pay for eligible dependent care expenses ($2,500 if married and filing a separate tax return).
Employee Assistance Program
Confidential and professional support services for problems of daily living and emotional wellbeing

Worklife Program
A variety of programs available to assist in finding balance in your personal and professional life. Programs offer support for adoption, dependent/elder care, housing and professional counseling.

Wellness Program
A wide array of wellness activities and services available as part of Healthy at Hopkins.

Other Voluntary Benefits
An opportunity to purchase a variety of supplemental insurance coverages at group rates through payroll deduction:

- Auto insurance
- Homeowner’s insurance
- Legal Insurance
- Travel Assistance and Identity Theft Protection
Eligibility and Enrollment

This section of your Handbook provides important information about participating in the myChoices benefits program, including who’s eligible, how you enroll, when coverage begins, and when you can make mid-year changes to your benefits. Be sure to review this information along with the detailed plan descriptions that follow.
Eligibility and Enrollment at a Glance

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

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

Who’s Eligible

Eligible Dependents

You may cover your eligible dependents under the medical, dental, voluntary vision, dependent life and AD&D insurance plans, as follows:

▪ Your legally married spouse or domestic partner (who qualify for coverage under the JHU Domestic Partner Policy as described “Domestic Partner Benefits Policy” on page 18); and

▪ Your child(ren) up until the end of the year in which the child turns age 26. Coverage may be continued for children up to any age, if they cannot support themselves because of a mental or physical disability (certification of disability is required and approved by JHU’s medical third-party administrators) that occurred before the end of the year in which the child turns age 26.

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

For life and AD&D insurance, ”children“ are: biological children, grandchildren, legally adopted children, children placed with the eligible employee for adoption, stepchildren, or children for whom the eligible employee or their spouse has been appointed legal guardian.

For details on whether a family member’s expenses can be paid from a health savings account (HSA), health care (or limited purpose) flexible spending account or a dependent care flexible spending account, see the separate explanations of those benefits.

Who’s Not Eligible

For all Plan benefits, you are not eligible to participate in the Plan if you are classified by your employer as:

▪ regularly scheduled to work fewer than the required hours per week as shown under Who’s Eligible above;

▪ a seasonal or temporary employee;

▪ a leased employee;

▪ an independent contractor;

▪ a nonresident alien who receives no US source income (within the meaning of the Internal Revenue Code) from JHU; or

▪ a member of a collective bargaining unit, unless the collective bargaining agreement provides for your participation in the Plan.

Proof of Dependent Eligibility Required

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

New Hires

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

Full time faculty, staff and bargaining unit members are also eligible to participate in the university’s voluntary benefit programs, which include Auto/ Homeowner’s Insurance, Legal Insurance, Critical Illness Insurance and Accident Insurance. Plan details can be found on the JHU Voluntary Benefits website at www.jhuvoluntarybenefits.com.

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

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

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

Annual Enrollment

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

Your elections will continue for the remainder of the calendar year unless you have a qualifying event. Mid-year changes are limited to those permitted as the result of a qualifying event. See “Qualifying Events” on page 20 for details.

Naming a Beneficiary

You need to name a beneficiary— the person(s) who receive benefits at your death for your life insurance, AD&D and business travel accident insurance benefits. Your AD&D beneficiary(ies) and business travel accident insurance beneficiary(ies) will be the same as your life insurance beneficiary(ies).

You may change your beneficiary(ies) at any time on the benefits enrollment site at https://hr.jhu.edu/benefits-worklife/. You may name anyone (one or more persons) as your beneficiary. If you name more than one beneficiary for any type of coverage, you must indicate what percentage (whole numbers only, no fractions) of the proceeds you would like them to receive.
The total of all percentages must equal 100%. If a named beneficiary dies before you, their share will be payable in equal shares to any other named beneficiaries who survive you.

If there is no designated beneficiary on file at the time of your death, benefits generally will be paid to persons related to you and who survive you, in the following order:

- Your lawful spouse;
- Your natural or legally adopted children;
- Your parents;
- Your natural or legally adopted brothers and sisters or
- Your estate.

If you die, the life insurance benefit your beneficiary receives will be tax-free. The beneficiary may work with the life insurance carrier to select a payment method at the time of the claim.

You are automatically the beneficiary of any dependent life insurance or dependent AD&D insurance coverage you elect.

## Coverage Levels and Cost of Coverage

You may choose one of the following coverage levels for medical, dental and voluntary vision:

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

* Must qualify for coverage under the JHU Domestic Partner Benefits Policy, described on page 18.

## Pre-tax Contributions

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

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

Federal law requires you to pay income taxes on the value of your employer-provided life insurance coverage (basic plus supplemental) over $50,000. The IRS treats coverage paid for by JHU, or paid for by you with pre-tax contributions, as “employer provided” for this purpose. The value of the cost of life insurance coverage over $50,000 is called “imputed income.” This amount is shown on your year-end W-2 form.
Salary Band Contributions (Faculty and Staff Only)

Medical contributions for the CareFirst BlueCross BlueShield PPO Plan, CareFirst High Deductible Health Plan (HDHP) and the EHP Classic Point-of-Service (POS) Plan are based on your salary as of January 1. If you become eligible at a later date, your coverage will be based on your salary on your eligibility date. Note that if your salary band changes due to a reduction in salary during the year, your contributions may be adjusted. The salary bands are as follows:

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

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

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

Domestic Partner Benefits Policy

JHU medical, dental and vision benefits are extended to domestic partners of eligible employees and those domestic partners’ children, provided the children qualify for coverage under the definition of dependent children. JHU AD&D and dependent life insurance are extended to domestic partners of eligible employees. To apply for benefits for your domestic partner and if eligible, your domestic partner’s children, you and your domestic partner must complete the JHU Affidavit of Marriage/ Domestic Partnership form available online at https://hr.jhu.edu/benefits-worklife/benefits-worklife-resources/benefits-forms-2/. This form should be completed with your benefit elections. If your domestic partnership ends, you must complete and submit the JHU Termination Statement of Marriage/ Domestic Partnership form available online at https://hr.jhu.edu/benefits-worklife/benefits-worklife-resources/benefits-forms-2/ within 30 days after the termination of your relationship.
Tax Treatment of Domestic Partner Benefits

Under federal law, domestic partners are not recognized as spouses. Therefore, if your domestic partner or any child of your domestic partner does not qualify as your dependent for federal income tax purposes (under special rules that apply for purposes of employer-sponsored health benefits), the Internal Revenue Code requires that the fair market value of any JHU-paid health benefits provided for that person must be treated as taxable income to you. (In general, your domestic partner or a child of a domestic partner generally will qualify as your dependent for federal income tax purposes only if they share the same principal residence as you for the applicable calendar year and you provide more than half of their support for the calendar year.)

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

When Coverage Begins

An eligible employee’s coverage for benefits selected in the myChoices Program generally starts on the first day of employment in an eligible status.

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

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

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

Elections made during annual enrollment period generally cannot be changed and will remain in effect from January 1 through December 31 of the following year. However, you may be permitted to change your benefit elections during the year (and outside of the annual enrollment period) under certain limited circumstances described herein.

Qualifying Events

You may change your benefit elections if you experience a qualifying event. To make changes, please contact the Benefits Service Center. Changes must be elected within 30 days of the qualifying event. Otherwise, you will not be able to change your benefits until the next annual enrollment period. Elections made during annual enrollment become effective January 1 of the following year. Elections made within 30 days of a qualifying status change will become effective on the date of the election.

You may be asked to submit additional forms related to your qualifying event, depending on the benefits being changed. Coverage changes are processed within a reasonable period of time after you make your election change, with the exception of medical coverage for a birth or adoption, when coverage is applied retroactively to the date of the event.

Changes in Status

The following changes in status are considered qualifying events:

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

- Reduction in hours of service: You and your dependents may drop your group health plan coverage under the Plan, even if you remain eligible for such coverage, if:
  - You were reasonably expected to work 30 hours per week and you experience a change in employment, after which you are reasonably expected to work less than 30 hours per week, and
  - You intend to enroll yourself and any dependents dropping coverage in another health plan (satisfying the Affordable Care Act’s definition of minimum essential coverage) effective no later than the first day of the 2nd month after you drop JHU coverage.
  - You are not permitted to change your health care flexible spending account or limited purpose flexible spending account elections because of a reduction in hours of service.

- Enrollment in a health plan offered through the public Marketplace: If you are eligible for a special enrollment period to enroll in public Marketplace coverage, or you want to enroll in public Marketplace coverage during the public Marketplace’s annual open enrollment period, you may drop group health plan coverage under this Plan, even if you remain eligible for coverage under this Plan. You (and any dependents whose coverage is dropped at this time) must intend to enroll in public Marketplace coverage that is effective no later than the day immediately following the last day your coverage under this Plan is dropped. You are not permitted to change your health Flexible Spending Account or Limited Purpose Flexible Spending Account elections because you intend to enroll in a plan offered through the public Marketplace.

You can make a new election in response to one of these qualifying events only if the election is on account of and consistent with the event. For example, in the case of marriage, birth, adoption or placement for adoption, you can change your medical coverage category to “2 adults + child(ren)” coverage. This includes changing medical plans.

Also, upon any change in status that affects eligibility under any employer’s plan, you may elect to either increase or decrease your coverage under a life insurance option, subject to any evidence of insurability requirements.

Special Enrollment Events

If you decline medical coverage because of other health insurance or group health plan coverage, you have 30 days to enroll yourself and your dependents in the Plan’s medical coverage features if you or your dependents lose eligibility for that other coverage (or if an employer stops contributing toward your or your dependents’ other coverage). In addition, if you have a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption, you have 30 days to enroll yourself and your dependents in the Plan’s medical coverage.

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

To request special enrollment or obtain more information, you can contact the Benefits Service Center.

Please note that Retirees are entitled to some, but not all, HIPAA special enrollment rights. See "Medical and Dental Benefits for Retirees" on page 65 for a discussion of the HIPAA special enrollment rights of retirees.

**Change in Cost or Coverage**

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

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

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

Other qualifying events include:

- A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires you or another individual to provide accident or health coverage for your child or a dependent foster child; or

- You, your spouse, domestic partner or dependent become covered or cease to be covered under Medicare or Medicaid.

**Leaves of Absence**

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

While on a leave of absence without pay, including FML:

- Medical, dental, vision, life, AD&D, dependent life insurance and short-term disability (STD) benefits (STD for up to three months) will be available on the same cost-sharing basis. You must continue to make payments on an after-tax basis during your leave.

- Payments from your health care flexible spending account (Health Care FSA) would be permitted for eligible health care expenses you incurred during the leave. Upon your return to work, your Health Care FSA contributions will be recalculated over the remaining pay periods left in the calendar year based on your Health Care FSA election amount.

- You have the right to discontinue any or all of your benefit elections during your leave of absence without pay by contacting the Benefits Service Center.

**Rehire Information**

*Please note that this section applies to active employee benefits only and does not apply to JHU’s retiree eligibility rules.*

If you terminate employment, and you are rehired within 30 days of termination (and within the same plan year), all your previous benefit elections may be reinstated, including your flexible spending account elections. You can also make new elections upon rehire if you choose.

If you are rehired after a longer period than described above, you will be eligible for benefits as a new hire subject to any waiting period that applies to new hires. You will not be subject to applicable waiting period if you are employed for one continuous year in a benefit eligible status, and your employment is terminated involuntarily due to a reduction in force and you are rehired within 12 months, or if you voluntarily resign in good standing and are rehired within six months (but later than 30 days).
When Coverage Ends

Your coverage under your health and welfare benefits generally will end on the earliest of the following dates:

▪ The end of the month in which your employment terminates or in which you cease to be an eligible employee for any other reason (such as because of a decrease in the number of hours worked or a transfer to an ineligible employee class);
▪ If you fail to make a required contribution for coverage, the last day for which you have paid for coverage;
▪ The date you report for active duty as a member of the armed forces of any country, unless you qualify to continue coverage under the JHU Military Leave Policy or applicable law (not applicable to life or AD&D insurance); or
▪ The date the plan is discontinued.

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

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

Coverage may also be terminated for any employee or dependent who engages in fraud or who makes a material misrepresentation of fact relating to coverage. In such cases, coverage may be terminated retroactively, if appropriate, based on the details. (Generally, your medical coverage will not be terminated retroactively, except to the extent permitted by applicable law and regulations.)

If you or your dependent(s) receive benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation, you may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. If you make any intentional misrepresentation or use fraudulent means concerning eligibility for coverage, changing your existing coverage, or benefits under the Plan, your coverage (and your dependents’ coverage) may be terminated irrevocably (including retroactively, to the extent permitted by law), and could be grounds for discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation. If your coverage terminates under certain conditions, you may have the right to elect continuation coverage for certain benefits offered under the plan. See “COBRA General Notice” on page 26 for more details.
Military Leave

If you take a military leave, whether for active duty or for training, you are entitled to extend your medical, dental, vision, employee assistance program benefits, life and AD&D insurance and the Health Care FSA or limited purpose FSA coverage for up to 24 months as long as you give JHU advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your total leave, when added to any prior periods of military leave from JHU, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit — including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

Generally, you will not be required to pay any more than the contributions required for active employees for coverage during your leave (including any amount for dependent coverage) who is not on military leave.

All other coverages will continue, to the extent such coverage is permitted under the applicable plan, and you make any applicable contributions, OR terminate during your military leave. Participation in the Dependent Care FSA will terminate.

If you are called to perform military service for more than 179 days, you will be able to take your unused Health Care FSA and/or limited Purpose FSA balance as a taxable cash distribution by the last day of the FSA plan year.

If you take a military leave, but your coverage under the Plan is terminated — for instance, because you do not elect the extended coverage — when you return to work at JHU, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health plan coverages. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.
If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months (see “COBRA General Notice” on page 26). However, your military leave benefits continuation period runs concurrently with your COBRA coverage period, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave, you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. (See the “COBRA General Notice” on page 26.) Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

**COBRA General Notice**

This section of the Handbook describes COBRA continuation coverage. This notice is provided to meet federal requirements that plan participants receive a copy of the COBRA general notice within 90 days of enrollment in the plan.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA continuation coverage is a temporary extension of coverage that can become available to certain individuals when they would otherwise lose your group health coverage under certain circumstances. COBRA applies only to the medical, prescription drug, dental, vision, Employee Assistance Program, onsite clinic, and health care (and limited purpose) flexible spending account benefits described in this Handbook and not to any other type of benefit. For additional information about your rights and obligations under the plan and under federal law, you should contact the Plan Administrator, Johns Hopkins University. Plan Administrator correspondence should be mailed to:

The Johns Hopkins University  
Office of Benefits Services  
Johns Hopkins at Eastern  
1101 E. 33rd Street, Suite C020  
Baltimore, Maryland 21218  
Telephone number: **410-516-2000**  
E-mail: benefits@jhu.edu

Please note:

- Under federal law, COBRA does not apply to coverage of domestic partners and their dependent. However, JHU voluntarily offers similar continuation options for such coverage. See “COBRA-Like Rights of Domestic Partners and Their Dependent Children” on page 31 for details.
- The following is only a summary of certain important provisions of COBRA. If you experience a COBRA “qualifying event” and provide required notice to the COBRA
Administrator by the applicable deadline, you will receive a COBRA Notice with additional information.

- COBRA is administered by WEX, which is referred to in this section as the COBRA Administrator
- You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the public Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

**What is COBRA Continuation Coverage?**

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

Employees become qualified beneficiaries if they lose coverage due to these qualifying events:

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

Spouses become qualified beneficiaries if they lose coverage due to these qualifying events:

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

Dependent children become qualified beneficiaries if they lose coverage due to these qualifying events:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”
Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to JHU, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

**When is COBRA Coverage Available?**

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

**The Individual Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), the individual must notify the Plan Administrator within 60 days after the later of (1) the date the qualifying event occurs, or (2) the date coverage would end because of the qualifying event. This notice must be provided, along with any required documentation to the Plan Administrator at the address noted in *Administrative Information* on page 115.

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

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

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

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

Each qualified beneficiary is required to pay the entire premium amount or cost of the group health plan including both employer and employee contributions for coverage of a similarly situated plan participant who is not receiving COBRA coverage. This amount may not exceed 102% (or 150% in the case of an extension of coverage due to disability). This amount may change during your period of COBRA coverage and will most likely increase over time. You will be notified of premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. If you do not make your first payment within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you fail to make a monthly payment before the end of the grace period, you will lose all rights to COBRA coverage under the Plan.

All COBRA premiums must be paid by check, money order, ACH debit or on-line credit card payment, as permitted by the COBRA Administrator, WEX. Your first payment and all monthly payments must be submitted on-line or mailed to WEX. If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact WEX to confirm the amount.

COBRA coverage is not effective until you elect it and make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

How Is COBRA Coverage Provided?

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

COBRA coverage is a temporary continuation of coverage.

For Health Care Plans (Except Health Care FSA)

When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee’s divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries other than the employee lasts up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which their employment terminates, COBRA coverage for their spouse and children can last up to 36...
months after the date of Medicare entitlement, which is equal to 28 months after the date of
the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is
the end of employment or reduction of the employee’s hours of employment, COBRA coverage
generally lasts for only up to a total of 18 months. There are two ways in which this 18-month
period of COBRA coverage can be extended, as described in the next two sections.

**Disability Extension of 18-Month Period of Continuation Coverage**

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

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

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

**Special Rules for Health Care Flexible Spending Accounts**

For a health care flexible spending account (“Health Care FSA”, which for purposes of this
section includes both general purpose and limited purpose FSAs), COBRA continuation coverage
is available only if the amount that a qualified beneficiary would be required to pay for the
coverage for the remainder of the plan year is less than the amount of reimbursements that
would be available to the qualified beneficiary if he or she elected COBRA coverage. Also, even
if COBRA continuation coverage is available, it is available only for the remainder of the plan
year in which the qualifying event occurs. COBRA continuation coverage for the Health Care
FSA cannot be extended beyond that time for any reason.
**EXAMPLE:** Assume that an employee elected to contribute a total of $1,200 to her Health Care FSA account for a plan year and then her employment terminates six months after the start of that plan year. By that time, she has contributed $600 to her Health Care FSA account through payroll deductions. Assume that she has already received $800 in reimbursements from her account for eligible expenses she paid before her employment terminated. In that case, the maximum benefit she could receive from her account for any eligible expenses she incurs for the rest of the plan year is $400. However, if she were permitted to continue to participate in the Health Care FSA for the rest of the plan year, she would be required to pay a total of $600 (plus about $12 in additional premiums allowed under COBRA) to continue that coverage. In that case, the amount she would be required to pay (about $612) is more than the maximum that she would be eligible to receive in reimbursements ($400), so she would not be offered COBRA continuation coverage under the Health Care FSA. On the other hand, if she had incurred expenses of $588 or less before her employment terminated, she would be offered the opportunity to elect COBRA continuation coverage under the Health Care FSA for the remainder of the plan year because her maximum benefit under the plan for the rest of the plan year would be more than the amount she would be required to pay ($612).

Any filing deadlines or other rules for filing a request for reimbursement under the Health Care FSA, as described earlier in this Summary Plan Description, will continue to apply if continuation coverage is elected under the Health Care FSA.

**Early Termination of Continuation Periods**

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

**If You Have Questions**

Questions concerning COBRA continuation coverage rights should be addressed to the COBRA Administrator:

WEX
PO Box 2926
Fargo, ND 58108-2926
866-451-3399

You may also contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

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

JHU currently provides “COBRA-like” health care continuation benefits to covered domestic partners and covered dependent children of domestic partners under terms similar to those that apply to spouses and dependent children entitled to COBRA rights. Domestic partners and covered children of domestic partners who believe they have experienced an event that gives
Eligibility and Enrollment

Summary Plan Description

Effective 1/1/22

rise to COBRA-like benefits are required to notify the Plan Administrator within 60 days of the date of that event in order to begin to enjoy these COBRA-like benefits. The termination of a domestic partnership will be treated like a divorce for purposes of this continuation coverage provided that the employee and their former domestic partner provide adequate documentation (as determined for JHU) of the date of termination of the domestic partnership within the 60-day deadline.

Continuing/Converting Coverage

Life Insurance

If you leave JHU or if you become ineligible for coverage, you may be able to continue all or a portion of your life, supplemental life, dependent life insurance coverage by applying to the insurance company for an individual policy.

In order to be eligible for full conversion under the life insurance policy, your coverage must end due to termination of employment or no longer being an eligible class of employee.

In order to be eligible for limited conversion under the life insurance policy, an employee must be insured for at least five years and coverage must terminate due to the group policy terminating or the policy being amended to reduce or terminate coverage.

To continue one or more of these coverages, you or your dependent must apply and pay the premium directly to the insurance company within 31 days after your JHU coverage ends. You must also meet any other requirements of the insurance company.

Coverage availability is based on the insurer’s policies.

You are not eligible to convert coverage if:

- you are disabled/out on a leave of absence, or if you become insured for another life insurance plan within 30 days of terminating under this plan, or
- You fail to pay the required premium under the policy.

Long-Term Disability

To be eligible to convert your LTD insurance, you must have been covered by the plan for at least 12 consecutive months on the date your coverage ends. You must apply for coverage with Lincoln Financial Group, pay the first premium within 30 days after your employment terminates, and meet any other requirements.

You are not eligible to convert coverage if you:

- Are or become insured under another group life or disability plan within 30 days after your termination of employment;
- Are disabled under the terms of the policy;
- Recover from a disability and do not return to work for JHU;
- Are on a leave of absence; or
• Have coverage under the policy that ends for any of the following reasons:
  □ The policy is canceled;
  □ The policy is changed to exclude the class of employees to which you belong;
  □ You end your working career or retire and receive payment from the JHU retirement plan; or
  □ You fail to pay the required premium under the policy.

**Portability Option**

If you leave JHU or retire, you may be able to take your life insurance and AD&D insurance with you and continue to pay group term life insurance rates directly to the provider. Rates may be higher than you paid as an active employee.

You cannot continue your coverage if:

• You are age 80 or older,
• You have converted your coverage to an individual policy, or
• Due to sickness or injury, you were not actively at work on the date prior to your termination of employment.
• There are maximum coverage levels available for portability. To learn more about your portability options, contact Securian at 1-866-365-2374.
Medical Coverage

JHU offers several medical plan options for you and your family, each of which provides coverage for a broad range of services and includes prescription drug coverage. The plans vary in the way you receive and pay for care. The options available to you may depend on your employment status.

Your JHU Medical Options

The Johns Hopkins University group health plans offer faculty, staff and bargaining unit employees several medical options, so you can choose the one that best meets your needs. Each option offers preventive care services at 100% (in-network), plus quality coverage to protect you and your family from the high cost of treating major illness and injury.

You can choose from the following medical plan options:

- CareFirst BlueCross BlueShield Preferred Provider Organization (PPO) Plan,
- EHP Classic Point-of-Service (POS) Plan— available to Faculty/Staff only,
- CareFirst BlueCross Blue Shield High Deductible Health Plan (HDHP) — available to Faculty/Staff only,
- Kaiser Permanente Health Maintenance Organization (HMO), and
- BlueChoice HMO (closed to new Faculty and Staff participants).

Declining Medical Coverage

You can also elect to waive medical coverage.

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

Annual Waiver Credit (Faculty and Staff)

If you are a Faculty and Staff member and you choose to waive medical coverage, you will be eligible for the annual waiver credit of $800 (if your salary is $40,000 or less) or $500 (if your salary is more than $40,000).
## Medical Options at a Glance

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

<table>
<thead>
<tr>
<th>JHU Medical Option</th>
<th>CareFirst BlueCross BlueShield PPO Plan</th>
<th>EHP Classic Point-of-Service (POS) Plan</th>
<th>CareFirst BlueCross Blue Shield High Deductible Health Plan (HDHP)</th>
<th>Kaiser Permanente Health Maintenance Organization (HMO)</th>
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<tbody>
<tr>
<td><strong>Network of Providers</strong></td>
<td>Allows you to go in-network or out-of-network every time you need care. You generally pay more for out-of-network care</td>
<td>Allows you to go in-network or out-of-network every time you need care. You generally pay more for out-of-network care</td>
<td>Allows you to go in-network or out-of-network every time you need care. You generally pay more for out-of-network care.</td>
<td>In-network care only. You select a primary care physician (PCP) who coordinates all of your care in the network.</td>
</tr>
<tr>
<td><strong>How You Pay for Services</strong></td>
<td>After the annual deductible has been met, you pay a percentage of the cost of the service received (called “coinsurance”). Once you reach the annual “out-of-pocket maximum,” the Plan pays for covered expenses at 100% for remainder of year.</td>
<td></td>
<td></td>
<td>Most services require a flat co-payment amount at the time care is received.</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$500 per individual $1,500 per family (combined in- and out-of-network)</td>
<td><strong>In-Network:</strong> $250 per individual/$750 per family <strong>Out-of-Network:</strong> $500 per individual/$1,500 per family</td>
<td><strong>In-Network:</strong> $1,750 per individual/$3,500 per family <strong>Out-of-Network:</strong> $3,500 per individual/$7,000 per family</td>
<td>N/A (copayment applies to most services)</td>
</tr>
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</table>
### Annual Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th>JHU Medical Option</th>
<th>CareFirst BlueCross BlueShield PPO Plan</th>
<th>EHP Classic Point-of-Service (POS) Plan</th>
<th>CareFirst BlueCross Blue Shield High Deductible Health Plan (HDHP)</th>
<th>Kaiser Permanente Health Maintenance Organization (HMO)</th>
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<tbody>
<tr>
<td><strong>CareFirst PPO</strong></td>
<td>$2,000 per individual ($1,500 per individual for BU employees) $6,000 per family ($4,500 for BU employees)*</td>
<td><strong>In-Network:</strong> $2,000 per individual/$6,000 per family* <strong>Out-of-Network:</strong> $4,000 per individual/$12,000 per family*</td>
<td><strong>In-Network:</strong> $3,500 per individual/$7,000 per family <strong>Out-of-Network:</strong> $7,000 per individual/$14,000 per family</td>
<td>$3,500 per individual $9,400 per family*</td>
</tr>
<tr>
<td><strong>EHP Classic POS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Kaiser HMO</strong></td>
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### Prescription Drug Costs

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<tr>
<th></th>
<th>No deductible, copay/coinsurance per drug category</th>
<th>No deductible, copay/coinsurance per drug category</th>
<th>No deductible, copay/coinsurance per drug category</th>
<th>Copay per drug category</th>
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### Annual Prescription Drug Out-of-Pocket Maximum

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<tr>
<th></th>
<th>Individual: $2,000 Adult + One Child: $4,000; Adult + Two or More Children: $6,000 2 Adults: $4,000 2 Adults and Child(ren): $6,000</th>
<th>Individual: $2,000 Adult + One Child: $4,000; Adult + Two or More Children: $6,000 2 Adults: $4,000 2 Adults and Child(ren): $6,000</th>
<th>Combined with medical out-of-pocket maximum</th>
<th>Combined with medical out-of-pocket maximum</th>
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### Access to Pre-Tax Spending Accounts

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<tr>
<th></th>
<th>Eligible for Health Care FSA</th>
<th>Eligible for Health Care FSA</th>
<th>Eligible for Health Savings Account (HSA) Also eligible for Limited Purpose FSA (for eligible dental and vision care expenses only)</th>
<th>Eligible for Health Care FSA</th>
</tr>
</thead>
</table>

*Note: The CareFirst PPO, EHP Classic POS and Kaiser HMO Plans have an embedded family out-of-pocket maximum. Once you or a covered dependent reaches the individual out-of-pocket maximum, the Plan pays 100% of that person’s eligible expenses for the rest of the calendar year. Once your family out-of-pocket maximum is reached, the Plan pays 100% of eligible expenses for the rest of the calendar year for you and all your covered dependents.
For Specific Plan Details

For a detailed summary of benefits coverage under each plan, including covered expenses, exclusions and limitations, see the specific plan information in the Appendix on page 148.

How Medical Coverage Works

All of JHU’s medical options provide comprehensive coverage for a broad range of services and include free preventive care (with no deductible) when you use an in-network provider, as well as coverage for mental health and substance abuse treatment, prescription drug benefits and various care management programs. The plans differ in how you receive and pay for covered services.

Some Important Medical Terms to Know

Deductible

You and each covered dependent must pay an amount each calendar year before the PPO, POS and HDHP options begin to pay benefits for most covered services. This amount is called the deductible. There is no deductible required under the HMO options.

Once you reach your annual deductible, the option pays a percentage of the reasonable and customary charges, subject to plan limits, for your remaining covered expenses in that year.

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

▪ Above reasonable and customary (R&C) charges (or the allowed benefit under the EHP POS option);
▪ Above any coverage limit;
▪ For any penalties that apply when you fail to pre-certify certain services as required;
▪ For any uncovered expenses;
▪ For prescription drug benefits (except under the HDHP option); or
▪ As copayments.

Medical Necessity

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

▪ Be necessary for the diagnosis, care or treatment of a condition;
▪ Be widely accepted among U.S. health care professionals as effective, appropriate and essential;
▪ Be based on the recognized standards of the health care specialty involved; and
▪ Not be provided solely for personal comfort or convenience.

The exact definition of “Medical Necessity” is determined by the plan in accordance with the provisions of the insurance policy or health plan document. See the plan summaries in the Appendix on page 148 for the definition.
In all cases, care must be provided, prescribed or approved by a legally qualified physician or practitioner who is practicing within the scope of their license and providing a covered service to be considered for coverage under the plan.

**Out-of-Pocket Maximum**

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

Once your expenses (including your deductibles) reach this amount for the calendar year, the option pays the full cost of your remaining covered expenses for that year, up to R&C charges (or the allowed benefit under the EHP POS option) and subject to coverage limits. You are responsible for any amounts in excess of R&C charges (or the allowed benefit), in excess of coverage limits, and for uncovered expenses. A new out-of-pocket maximum applies to your share of covered expenses each year.

**How the Family Out-of-Pocket Maximum Works**

**The CareFirst PPO, EHP Classic POS and Kaiser HMO Plans have an embedded family out-of-pocket maximum.** Once you or a covered dependent reaches the individual out-of-pocket maximum, the Plan pays 100% of that person’s eligible expenses for the rest of the calendar year. Once your family out-of-pocket maximum is reached, the Plan pays 100% of eligible expenses for the rest of the calendar year for you and all your covered dependents. So for example, if you are enrolled in the CareFirst PPO option and one covered family member reaches the individual $2,000 out-of-pocket maximum ($1,500 for BU employees), then covered expenses for that member are covered in full for the remainder of the calendar year.

The family out-of-pocket limit may be satisfied by any combination of covered expenses incurred by any covered family member. However, no one family member may contribute more than the individual out-of-pocket maximum.

**The CareFirst HDHP has a true family out-of-pocket maximum.** The entire family out-of-pocket maximum must be satisfied before the Plan pays 100% of expenses for any one covered member for the rest of the calendar year.

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

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

View the Medical Plan Comparison online at www.hr.jhu.edu/benefits-worklife for a side-by-side look at how your medical plan options compare.

You can also find a detailed plan summary for each option in the Appendix on page 148.

CareFirst BlueCross BlueShield PPO Medical Plan

This plan provides traditional coverage, which means you pay your deductible first, and then you pay a portion of the cost (your coinsurance amount) each time you use medical services. You generally pay less for care when you use a provider in an approved network.

▪ If you use a provider in the JHU Preferred Physician Network, for most covered services, the coverage is 100% after you meet a deductible. The list of providers in the JHU Preferred Physician Network may be accessed here: https://hr.jhu.edu/benefits-worklife/health-life/medical/plan-options/carefirst-bcbs/.

▪ If you use a provider who is not a member of the JHU Preferred Physician Network, the plan pays 70% of the allowed benefit for most covered services, after you meet a deductible.

▪ There are limits to the amount you have to pay out of your pocket each year (your out-of-pocket maximum). Once you meet your out-of-pocket maximum, the plan pays 100% of the remaining eligible expense for that year. The family out-of-pocket limit may be satisfied by any combination of covered expenses incurred by any covered family member. However, no one family member may contribute more than the individual out-of-pocket maximum.

▪ For preventive services, your coverage is 100% before the deductible.

Please note: Certain health care providers have contracted with CareFirst to limit the amount they may charge participants. The amount these providers charge is, in effect, "discounted." If you use a provider who is not a member of the JHU Preferred Physician Network but who has contracted with CareFirst, your coverage is still 70%, but the portion you pay (30% of the allowable charges) will generally be less than what you would pay for a provider without the same relationship with CareFirst because you are paying 30% of a "discounted" charge.

EHP Classic Point-of-Service (POS) Plan — Faculty and Staff Only

This plan is a Point-of-Service (POS) plan, which provides broad medical coverage and the flexibility to use any provider you choose. You generally pay less when you use providers who are part of the Johns Hopkins Employer Health Program (EHP) network. The EHP Classic POS Plan does not require you to select a primary care physician (PCP). Please note that this Handbook is not the SPD for the EHP plan. Please refer to the EHP SPD as listed on the Appendix on page 148.

▪ Care for most eligible expenses provided by an EHP provider is covered at 80% of the allowed benefit, after a deductible. No referrals are needed.

▪ If you see an out-of-network provider, most covered services are paid at 70% of the allowed benefit, after a deductible.
Once you meet your out-of-pocket maximum, the plan pays 100% of the remaining eligible expense for that year. The family out-of-pocket limit may be satisfied by any combination of covered expenses incurred by any covered family member. However, no one family member may contribute more than the individual out-of-pocket maximum.

For preventive services, your coverage is 100% before the deductible.

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

CareFirst BlueCross BlueShield High Deductible Health Plan (HDHP) — Faculty and Staff Only

The High Deductible Health Plan (HDHP) works much like a traditional point-of-service (POS) medical plan — giving you the flexibility to use in-network or out-of-network providers. However, it features a higher deductible and out-of-pocket maximum than a traditional POS. While the employee premium is lower, you have to pay more health care and prescription drug costs yourself before the plan starts to pay.

Once you meet your out-of-pocket maximum, the plan pays 100% of the remaining eligible expense for that year. The entire family out-of-pocket maximum must be satisfied before the Plan pays 100% of expenses for any one covered member for the rest of the calendar year.

For preventive services (including certain preventive prescription drugs), the plan pays 100% even before you meet the deductible.

Like the POS plan, you’ll generally pay less when you use an in-network provider. However, you can choose to use an out-of-network provider at any time.

What makes this type of plan unique is that it pairs with a special Health Savings Account (HSA). See the Health Savings Account (HSA) on page 75 for information about the HSA.

Kaiser Permanente Medical Plan HMO

This plan is a health maintenance organizations (HMO), which provides broad medical coverage that must be coordinated by your HMO’s primary care physician (PCP). You are limited to using physicians and facilities that are part of your HMO’s network of providers (except in an emergency). There are limits to the amount you have to pay out of your pocket each year (your out-of-pocket maximum). Most eligible expenses are covered at 100% or require a small copayment. Hospital inpatient admission requires a $250 copayment ($100 copayment for bargaining unit).

Once you meet your out-of-pocket maximum, the plan pays 100% of the remaining eligible expenses for that year. The Kaiser Permanente HMO has an embedded family out-of-pocket maximum. Once a covered member satisfies the individual out-of-pocket maximum, the Plan pays 100% of the remaining eligible expenses for that individual for the rest of the year.
Annual out-of-pocket maximum

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<tr>
<td><strong>Individual</strong></td>
<td>$3,500</td>
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<tr>
<td><strong>1 Adult and Child(ren)</strong></td>
<td>$7,000 for Adult + one child; $9,400 for Adult + two or more children</td>
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<tr>
<td><strong>2 Adults</strong></td>
<td>$7,000</td>
</tr>
<tr>
<td><strong>2 Adults and Child(ren)</strong></td>
<td>$9,400</td>
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**BlueChoice HMO Plan**

(This plan is closed to new faculty and staff participants effective January 1, 2010)

BlueChoice is a health maintenance organization (HMO) — a managed health care plan that offers comprehensive medical care. You must use the HMO’s doctors and facilities to receive benefits. The BlueChoice network consists of independent physicians with offices located throughout the community. Most eligible expenses are covered at 100% or require a small copayment. Hospital inpatient admission requires a $250 copayment for faculty and staff.

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

**For Faculty and Staff**

Annual out-of-pocket maximum

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<tr>
<td><strong>Individual</strong></td>
<td>$2,000</td>
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<tr>
<td><strong>1 Adult and Child(ren)</strong></td>
<td>$4,000 for adult + one child; $6,000 for adult + two or more children</td>
</tr>
<tr>
<td><strong>2 Adults</strong></td>
<td>$4,000</td>
</tr>
<tr>
<td><strong>2 Adults and Child(ren)</strong></td>
<td>$6,000</td>
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**For Bargaining Unit Employees**

Annual out-of-pocket maximum

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<tr>
<td><strong>Individual</strong></td>
<td>$1,500</td>
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<tr>
<td><strong>1 Adult and Child(ren)</strong></td>
<td>$3,000 for adult + one child $4,500 for adult + two or more children</td>
</tr>
<tr>
<td><strong>2 Adults</strong></td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>2 Adults and Child(ren)</strong></td>
<td>$4,500</td>
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</table>
HMO Participants Must Designate a Primary Care Physician

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

When you need to see a specialist, your PCP can help you determine what treatment is right for you and will recommend an appropriate provider. Find more information about choosing a PCP, see the specific plan materials in the Appendix on page 148.

What to Do in an Emergency

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

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

“Medical emergency” has different meanings, depending on the plan in which you participate. See the plan summaries in the Appendix on page 148 for a description of a medical emergency under your plan.

In case of an emergency, if you are admitted to the hospital, you (or someone on your behalf) must notify the insurance carrier within 48 hours of the admission.

Telehealth Services

Telehealth services offer a convenient way to get medical care for non-emergency needs and are covered at 100% for 2022. Each health plan has access to a telehealth app that allows you to get the care you need, when and where you need it. You can talk with a doctor by video on your smartphone, tablet, or computer. You can see a provider online if you need treatment for a common condition such as a sinus infection or a sore throat. For mental health, diet/nutrition, or breastfeeding support, you can schedule a virtual visit and meet with a licensed professional from the comfort of your home.

- CareFirst Members: Download the CareFirst Video Visit app and enter your insurance information from your CareFirst card or access via the CareFirst website at https://individual.carefirst.com/individuals-families/home.page
- EHP Members: EHP members have access to an exclusive EHP telehealth app or access via the EHP website at https://www.ehp.org/
- Kaiser Members: You must register with www.KP.org to get started using telehealth services.
What the Options Cover

The medical options provide coverage for a broad range of covered services, including preventive care as required by the Affordable Care Act to be covered at 100%, physician and provider services, hospital services, mental health and substance abuse services, and more.

For a complete list of covered services under your plan, please refer to the plan summary included in the Appendix on page 148.

What the Options Don’t Cover

See the plan summaries in the Appendix on page 148 for a detailed list of exclusions under your medical option. Please note that any services or prescription drugs not permitted under applicable state or local laws are excluded. Some state or local laws restrict the scope of health care services that a provider may render, or prescription drugs that a provider may prescribe. In such cases, medical options will not cover such health care services or prescription drugs unless a participant or dependent travels to a state or locality without such a restriction to receive such care or prescription drugs.

Prescription Drug Benefits

Express Scripts

Express Scripts is the plan’s pharmacy benefit manager and administers prescription drug benefits for the CareFirst BlueCross BlueShield PPO and HDHP, EHP Classic POS, BlueChoice HMO options. Prescription drug benefits under the Kaiser Permanente HMO are provided directly by Kaiser.

Subject to all plan limits and provisions, the plan covers an approved list of prescription drugs (formulary). A formulary is a list of drugs reviewed and approved by Express Scripts’ coverage criteria. The formulary includes drugs that are commonly prescribed, clinically useful and cost effective. Not all medications are covered by the prescription drug benefit.

Three categories of drugs make up the formulary:

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

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

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

When you purchase your medication, the amount of your copayment will depend on which tier your drug falls under. Some medications are covered at 100% as required under the Affordable Care Act for preventive items and services. You may purchase your prescriptions either through a retail pharmacy or through the mail-order program.

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

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

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

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

There are limits to the amount you have to pay out of your pocket each year (your out-of-pocket maximum) for prescription drug expenses. Once you meet your out-of-pocket maximum, the plan pays 100% of the remaining eligible expenses for that year. You would still be responsible for paying for any uncovered expenses. Expenses incurred in one year cannot be applied towards meeting your out-of-pocket maximum in the next year. Note that under the CareFirst HDHP, the medical and prescription drug out-of-pocket maximum are combined.
### Annual Prescription Drug Out-of-Pocket Maximum

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<tr>
<th></th>
<th>CareFirst PPO, EHP Classic POS, BlueChoice HMO, and CareFirst III Plans</th>
<th>CareFirst HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>$2,000</td>
<td>Combined with medical out-of-pocket maximum</td>
</tr>
<tr>
<td><strong>1 Adult and Child(ren)</strong></td>
<td>$4,000 for adult + one child;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$6,000 for adult + two or more children</td>
<td></td>
</tr>
<tr>
<td><strong>2 Adults</strong></td>
<td>$4,000</td>
<td></td>
</tr>
<tr>
<td><strong>2 Adults and Child(ren)</strong></td>
<td>$6,000</td>
<td></td>
</tr>
</tbody>
</table>

**Mandatory Generics**

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

**Drug Quantity Management**

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

**Step Therapy**

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

**Prior Authorization**

Some medications will require prior authorization or review and approval before the plan covers the cost. This review includes a review of rules for FDA-approved prescribing and safety information and clinical guidelines. This is to ensure that the medication you receive is safe and effective for your condition. Failure to obtain prior authorization may result in denial of the claim.
To find out whether a medication requires a coverage review, log in to express-scripts.com. Select “Price a medication” under “Manage Prescriptions”, and search for your medication. On the results page, select ‘View coverage notes” to see coverage details.

If your medication needs approval, either you or your pharmacist will need to notify your doctor. Your doctor will then need to switch your medication to meet Express Scripts recommendations or you may contact them at 1-888-406-1213 to begin the approval process.

**Specialty Pharmacy Copay Assistance Program**

Under Express Scripts’ specialty pharmacy copay assistance program, SaveonSP, certain specialty pharmacy drugs are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the participant’s out-of-pocket maximum. Although the cost of the program drugs will not be applied towards satisfying a participant’s out-of-pocket maximum, the cost of the program drugs will be reimbursed by the manufacturer at no cost to the participant. Copays for certain specialty medications may be set to the maximum of the current plan design or any available manufacturer-funded copay assistance. To learn which prescriptions may be eligible under this program, visit www.saveonsp.com/jhu.

**Kaiser Permanente**

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

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

(A refill prescription normally will be sent out within five days upon receipt of the order.)
Order by fax. Complete the EZ Refill prescription form available at any Kaiser Medical Center and fax it to 703-709-1688.

Order by email. Members can visit the website at www.kp.org and order refills.

When you purchase your medication, the amount of your copayment will depend on whether your prescription is generic or brand, or non-formulary and whether you are purchasing it from a Kaiser pharmacy or a community pharmacy.

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

There are limits to the amount you have to pay out of your pocket each year (your out-of-pocket maximum). This maximum includes your copays for prescription drugs. Once you meet your out-of-pocket maximum (combined for medical and prescription drugs), the plan pays 100% of the remaining eligible expenses for that year.

### Important Notices

#### Qualified Medical Child Support Orders

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

#### The Newborns’ and Mothers’ Health Protection Act

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

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
In certain cases, you may be entitled to other protections under state law. For example, if your medical benefits are provided under an insurance policy issued in Maryland, the following applies under state law:

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

**Women’s Health and Cancer Rights Act of 1998**

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

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

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

These reconstructive benefits are subject to any applicable deductible and coinsurance limitations that are consistent with those applicable to other medical and surgical benefits covered under the plan.

**Coordination of Benefits**

*When You Have Other Coverage*

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

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

- The primary plan pays benefits first, without regard to any other plan; then
- The secondary plan pays any benefits covered by the secondary plan that are not covered by the primary plan.
If a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an eligible expense and a benefit paid. No plan pays more than it would without the coordination provision.

Here’s how coordination of benefits works:

- The plan that is primarily responsible for a person’s expenses — the plan that pays benefits first — is considered primary coverage for that person:
  - If the other plan doesn’t have a coordination of benefits provision, it is primary;

If the other plan has a coordination of benefits provision:

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

This plan will pay the lesser of:

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

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

(A) 100% of “allowable expenses” incurred by the person for whom the claim is made

Less

(B) Benefits payable by the “other plans”

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

- The plan covering the parent who has financial responsibility for medical expenses under a court decree is primary;
- If there is no court decree, then:
  - First, the plan of the parent with legal custody of the child;
  - Then, the plan of the new spouse or domestic partner (if any) of the parent with legal custody of the child; and then
  - The plan of the natural parent without custody of the child.
If there is a court decree which provides that parents share joint custody of a covered child, without stating that one of the parents is responsible for health care expenses of the child, then the birthday rule determines which plan (JHU’s or the other parent’s) is primary. The plan covering the parent whose birthday falls earlier in the year is primary. If you and the child’s other parent have the same birthday, the plan covering you or the other parent for the longer period of time is primary.

**Coordination of Benefits with Medicare**

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

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

- Eligible employees age 65 and above with current employment status and spouses age 65 and above who participate in this plan on the basis of the employee’s current employment status;

- Social Security disabled individuals who are covered by this plan on the basis of current employment status (their own or a family member’s current employment status) and who are entitled to Medicare benefits based on disability (e.g., an employee’s disabled spouse or child); and

- For the first 30 months of Medicare entitlement, for certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD), regardless of the reason for the employer coverage.

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

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

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

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

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

After your claim has been submitted, you will receive an Explanation of Benefits (EOB) that describes what benefits the plan paid and, if applicable, what expenses were not covered. A check will be attached to the EOB unless you’ve assigned benefits to your provider.

If your claim is denied, you may request in writing that your claim be reconsidered. Read more about denied claims in Administrative Information on page 115.
Onsite Health Clinics

JHU offers on-site health clinics that provide convenient access to care for eligible employees.

The onsite clinics include the:

- Employee Health & Wellness Center, and
- East Baltimore and Homewood Occupational Health Services.

Eligibility

Services are for benefit-eligible employees of JHH or JHHSC.

If you are enrolled in the CareFirst BlueCross Blue Shield High Deductible Health Plan (HDHP), you will not have access to the onsite clinics for services outside of work-related injuries or preventive care until you have satisfied your annual deductible.

Employee Health & Wellness Center

Not feeling well? Get the care you need quickly so you can return to work sooner. The Employee Health & Wellness Center offers free visits by appointment for non-emergency, non-work related illnesses and musculoskeletal injuries, including:

- colds
- cough
- red eye
- influenza
- sore throat
- sinus problems
- rash
- upset stomach
- fever
- sprains
- strains

The Employee Health & Wellness Center’s team of nurse practitioners, registered nurses and support staff provides referrals, limited lab services, and treatment of illnesses, including prescriptions.

Note: The clinic is only to be utilized while at work, you must first report to work and have your supervisor sign and complete the Employee Health and Wellness Authorization Form available online at http://intranet.insidehopkinsmedicine.org/human_resources/download_forms/#Healthy.
**Location and Hours**

Phipps Building, Suite 351  
600 Wolfe Street  
Baltimore, MD 21287

The Employee Health & Wellness Center is open Monday through Friday from 7:00 a.m. to 5 p.m.

We value your time and recommend making an appointment for a daytime visit by calling 410-614-1620.

**Employee After-Hours Clinic**

Extended hours are available Monday through Thursday from 5 p.m. to 10 p.m.

The After-Hours Clinic is located at Blalock 144 in The Johns Hopkins Hospital.

Evening appointments can be made by calling 410-955-7374.

**Occupational Health Services**

Both East Baltimore and Homewood Occupational Health Services supports all levels of Johns Hopkins Medicine and University Institutions in the pursuit of a quality work environment that is free from recognized health, safety, and environment risks and is in compliance with applicable regulations. We provide direct access to professional expertise for employees in their pursuit of health and well-being.

The vision of the Occupational Health Services as a part of Health Safety and Environment is a recognized partner of the Johns Hopkins Institution management team. Our technical knowledge is accepted as a valued and added service to the organization. Our proactive approach to collaborating, facilitating, and educating distinguishes us as a premier model in our field.

- Increase health and safety awareness education to all Hopkins employees.
- Facilitate regulatory compliance and avoid violations.
- Identify and define areas of management / employee responsibility and accountability in the HSE arena.
- Provide services in an innovative, cost effective manner.
- Establish, implement and review measurements.
- Foster ongoing cooperative, supportive relationships with our customers.
- Obtain and utilize resources and tools for maximum performance and productivity.
- Foster a creative, open work environment with supports out team, as well as individual, professional growth.
Available Services

Preventive Medicine

- Immunizations
  - Hepatitis B
  - MMR (mumps, measles, rubella)
  - Varicella (chickenpox)
  - Tetanus
  - Vaccinia (smallpox)
  - Rabies
  - Influenza (flu)
  - COVID-19

Surveillance

Tuberculosis - Screening for employees annually as required by regulations and for exposures to TB. Have questions about Tuberculosis Screening? Read the FAQs available online at https://www.hopkinsmedicine.org/hse/forms/TBfaq.pdf

- Hearing Conservation - Scheduling and reviewing hearing test then interviewing all exposed employees
- Respirator Program - Medical assessment including pulmonary function testing of all employees identified as needing to wear a respirator in their job assignment
- Laser Program - Scheduling and evaluation of all employees with laser exposure
- Ethylene Oxide Program - Periodic testing of employees with exposure as necessary

INH Evaluation

- Evaluation and treatment as necessary for PPD converters

Communicable Disease Exposure

- Evaluation and treatment of all employees identified as being exposed to patients with a communicable or contagious disease, i.e., varicella, meningitis, pertussis

HIV Testing

- Free, confidential testing provided upon employee's request.
**Pre-Placement Health Screening**

- Vision check
- Drug screening
- TB testing (Have questions about Tuberculosis Screening? Read the FAQs available online at https://www.hopkinsmedicine.org/hse/forms/TBfaq.pdf)
- Tdap vaccination and other vaccinations needed for position
- B/P, Pulse
- Review of health history

**ADA Compliance**

- Job assessments and employee assessments for accommodation
- Handicapped parking as necessary

**Physician Credentialing**

- Review of records
- Immunize as necessary
- Urine Drug Screening

**Return-to-duty Clearance**

- Employees absent from work for more than 3 days due to a communicable or contagious disease. Employees with non-job related injuries / accidents Hospitalization / out-patient procedures.

**Employee Assistance**

**Health Screening**

- Employees c/o being sick at work
- Evaluation for ability to continue at work
- B/P checks

**Fitness for Duty**

- Employees are referred by supervisors prior to entering the disciplinary process for evaluation to assess medical problems affecting the employee's ability to work.

**Drug Testing**

- Random and for cause drug testing of employees referred by supervisors or substance abuse counselors

**Hearings**

- Unemployment
- Grievance
- EEO testimony
**Occupational Injuries**

- The Department of Occupational Health Services at Eastern provides immediate treatment for all work-related injuries and illness. We provide referrals to specialists within the Johns Hopkins Institutions and effective case management for injury prevention and control.

**Homewood Campus**

- If you are injured at work, please notify your supervisor immediately and contact the Homewood Office of Occupational Health Services at 443-997-1700.
- If an injury should occur on a night shift or weekend, please seek the appropriate medical treatment and follow-up with the Department of Occupational Health Services the next business day.

**East Baltimore Campus**

- If you are injured at work due to an occupational injury please notify your supervisor immediately and contact the Injury Clinic Office in the Johns Hopkins Hospital at 410-955-6433.

Employee Incident Report Form & the Occupational Health Services Employee Information Form are available at the Health and Safety Forms web page.
Critical Illness Insurance

Critical Illness Insurance provides you with a lump-sum benefit if you are diagnosed with a covered critical illness and can supplement your other medical coverage.

Critical Illness Insurance at a Glance

Critical Illness Insurance from MetLife is designed to give you the peace of mind needed to concentrate on recovery instead of finances. You choose an Initial Benefits Amount of:

- $10,000,
- $15,000 or
- $20,000.

Eligibility and Enrollment

As a full-time faculty, staff and bargaining unit member who is actively at work, you can participate in a voluntary benefits program to purchase Critical Illness Insurance. You may purchase it for yourself, as well as for your spouse/domestic partner and your dependent children up to age 26. Coverage is guaranteed issue if elected within 30 days of hire.

Rates and additional plan details can be found on the Johns Hopkins University Voluntary Benefits website at www.jhuvoluntarybenefits.com. Enrollment is completed online. If you wish to speak with a service representative, contact Mercer, the administrators of our voluntary benefits program at 866-795-9362.
How the Coverage Works

Although not a replacement for traditional medical or disability insurance, MetLife Critical Illness Insurance provides a lump-sum payment in the event that you or a covered dependent experience one of the following medical conditions and meet the policy and certificate requirements:

- Cancer
- Heart Attack
- Stroke
- Alzheimer's Disease
- Kidney Failure
- Coronary Artery Bypass Graft
- As well as many other conditions

From co-pays and deductibles to mortgage payments and child care, you can use the lump-sum payment as you see fit to help protect your family’s finances so you can focus on recovery.

Filing Claims for Benefits

Contact Mercer, the administrators of our voluntary benefits program at 866-795-9362 as soon as you think you may have a claim.
Accident Insurance

Accident Insurance provides you and your family with a cash benefit, unless you choose otherwise, in the event of an accident. It’s designed to provide financial support throughout different stages of care: Ambulance services, emergency treatment, hospital admission, intensive care unit, travel expenses to distant treatment centers, everyday living expenses (groceries, rent or mortgage, utilities or groceries), etc.

Accident Insurance at a Glance

The Accident Insurance Plan gives you the ability to purchase low-cost coverage that pays benefits if involved in an accident off the job.

Eligibility and Enrollment

As a full-time faculty, staff and bargaining unit member, you can participate in a voluntary benefits program to purchase Accident Insurance. You may purchase it for yourself, as well as for your spouse/domestic partner and your dependent children.

Rates and additional plan details can be found on the Johns Hopkins University Voluntary Benefits website at www.jhuvoluntarybenefits.com. Enrollment is completed online. If you wish to speak with a service representative, contact Mercer, the administrators of our voluntary benefits program at 866-795-9362.
How the Coverage Works

Accident Insurance from MetLife can help protect you and your family from the unexpected expenses of an accident that occurs off the job such as:

- Sports-related accidental injuries
- Broken bones
- Burns
- Concussions
- Lacerations
- Back or knee injuries

Accident Insurance helps to offset medical costs, such as emergency room fees, deductibles and co-payments that can result from a covered accident.

Features of MetLife’s Accident Insurance include:

- Premiums are conveniently paid through payroll deduction.
- Benefits are paid directly to you.
- Benefits are paid regardless of any other insurance you may have with other companies.
- Coverage is portable; you can take it with you if you change jobs or retire.

Filing Claims for Benefits

Contact Mercer, the administrators of our voluntary benefits program at 866-795-9362 as soon as you think you may have a claim.
Dental Coverage

Good dental care is an important part of your overall health. For this reason, JHU offers you a choice of two dental options through Delta Dental for you and your eligible dependents.

Your dental plans provide coverage for a full range of dental services. Orthodontia is only covered under the Enhanced Plan.

Dental at a Glance

The following table is an overview of covered services. For a complete plan summary, see the Appendix on page 148.

<table>
<thead>
<tr>
<th>Service</th>
<th>Delta Dental Standard Plan</th>
<th>Delta Dental Enhanced Plan with Orthodontia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$75 per person / $150 per family each calendar year</td>
<td>$50 per person / $100 per family each calendar year</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$75 per person / $150 per family each calendar year</td>
<td>$50 per person / $100 per family each calendar year</td>
</tr>
<tr>
<td><strong>Diagnostic &amp; Preventive Services (D &amp; P)</strong></td>
<td>100% of contracted fees</td>
<td>100% of program allowance</td>
</tr>
<tr>
<td>Exams, cleanings, X-rays and sealants (no deductible applies)</td>
<td>100% of contracted fees</td>
<td>100% of program allowance</td>
</tr>
</tbody>
</table>

**DELTA DENTAL STANDARD PLAN**

**DELTA DENTAL ENHANCED PLAN WITH ORTHODONTIA**
### Your Dental Coverage Options

Dental coverage options available to you are:

- Delta Dental Standard Plan
- Delta Dental Enhanced with Orthodontia Plan

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

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<table>
<thead>
<tr>
<th></th>
<th><strong>DELTA DENTAL STANDARD PLAN</strong></th>
<th></th>
<th><strong>DELTA DENTAL ENHANCED PLAN WITH ORTHODONTIA</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network</strong></td>
<td></td>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td></td>
<td><strong>Out-of-Network</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Basic Services:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>fillings, root canals, periodontics, oral surgery</td>
<td>70% of contracted fees</td>
<td>70% of program allowance</td>
<td>90% of contracted fees</td>
</tr>
<tr>
<td><strong>Major services:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowns, inlays, onlays and cast restorations and TMJ, Bridges, dentures and implants</td>
<td>50% of contracted fees</td>
<td>50% of program allowance</td>
<td>60% of contracted fees</td>
</tr>
<tr>
<td><strong>Calendar Year Maximum Benefit</strong></td>
<td>$1,000 per person each calendar year, includes D&amp;P services</td>
<td>$1,000 per person each calendar year, includes D&amp;P services</td>
<td>$2,000 per person each calendar year, includes D&amp;P services</td>
</tr>
<tr>
<td><strong>Orthodontia</strong> (no deductible applies)</td>
<td>Not covered</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong> (Orthodontia only)</td>
<td>Not applicable</td>
<td>$2,000 total for in-network and out-of-network orthodontic services.</td>
<td></td>
</tr>
</tbody>
</table>

Please note: “Program allowance” are the negotiated fee that is determined to be reasonable and customary by the insurance company. For comparison purposes, the amounts have been converted to percentages for use in this chart only.
How Dental Coverage Works

The Delta Dental of Pennsylvania dental plans operate as preferred provider organization (PPO) plan. Network “preferred providers” under these plans have agreed to provide service at a lower cost to you than non-preferred providers. Visit a dentist in the Delta Dental PPO network to maximize your savings. Delta Dental Premier® dentists offer the next best opportunity to save. PPO and Premier preferred providers are considered to be “in network” and non-preferred providers are “out of network.” If you enroll in either Delta Dental plan, you will receive a membership card.

What the Dental Options Cover

Dental coverage under the JHU options is divided into four categories of service, generally described as:

- Preventive & Diagnostic,
- Basic,
- Major, and
- Orthodontia (not covered under the Standard Plan).

The cost of covered services varies for each category and for the type of dental provider you see (in network or out of network). See the Plan Summary in the Appendix on page 148 for details about covered services.

What’s Not Covered

Limitations

Certain age and frequency limitations apply to covered dental services.

Additional limitations apply to services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “Optional Services”. Optional Services also include the use of specialized techniques instead of standard procedures.

See your plan summary included in the Appendix on page 148 for a complete list of limitations.

Exclusions

See your plan summary included in the Appendix on page 148 for a complete list of dental plan exclusions.

Predetermination of Benefits

Delta Dental suggests you obtain predetermination of benefits prior to extensive proposed and/or planned work (e.g., work that could exceed $300). Predetermination lets you know whether the service is covered and if the amount would be paid by the plan.
Services In-progress When Coverage Ends

Services that began before the date your coverage terminates will be covered. Orthodontic services will terminate when your coverage terminates.

Filing Dental Claims for Benefits

You must file claims for out-of-network care under both the Delta Dental of Pennsylvania dental options. For in-network care, your dental provider will complete and submit the claim forms.

Detailed information can be found in your plan summary included in the Appendix on page 148 for more details.

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

After your claim has been submitted, you will receive an Explanation of Benefits (EOB) that describes what benefits the plan paid and, if applicable, what expenses were not covered. A check will be attached to the EOB unless you’ve assigned benefits to your provider.

If your claim is denied, you may request in writing that your claim be reconsidered. Read more about denied claims in Administrative Information on page 115.
Having adequate health care coverage is an important consideration when you retire. JHU offers retiree medical and dental coverage for eligible retirees and their eligible dependents—the same coverage available to active employees and their families—as long as the retiree meets certain eligibility criteria for age and service.

### Retiree Coverage At-a-Glance

- You may continue your medical and dental coverage after you retire under the Retiree Health Plan, as long as you satisfy the criteria below:
  - you leave JHU in good standing (as determined by JHU), and
  - at the time you leave JHU you are at least age 55 with 10 years of continuous full-time service on or after age 55 or have completed at least 30 years of continuous full-time service.

- JHU may pay a portion (called a subsidy) of the cost of your retiree medical coverage depending upon your age, length of service, and year of retirement. You pay the full cost of retiree dental coverage.

- If you want to continue your medical and dental coverage, you must enroll within 30 days of your retirement—you may cover yourself, your spouse domestic partner, and/or your dependent children.

- Most medical and dental plan options under the Retiree Health Plan are the same as the options available to active employees at the time you retire. However, for Bargaining Unit employees who are enrolled in the BCBS Plan II, the retiree plan design for this plan is slightly different. Please refer to your CBA for more information.

- Please note that JHU’s retiree medical plan pays secondary to Medicare for any members and/or spouses that are over age 65 or otherwise Medicare eligible. You and your dependents must enroll in Medicare as soon as possible; claims will be processed as if they were submitted to Medicare first (whether or not you or your dependent actually enrolls in Medicare).
Who’s Eligible

You are eligible for retiree medical and dental coverage only if you retire from JHU in good standing (as determined by JHU), AND:

- Are at least age 55 and have 10 or more years of continuous full-time service on or after age 55, OR
- You have 30 or more years of continuous full-time service.

Please note: A leave of absence from which you do not return to full-time service does not count toward satisfying the service requirement except when on disability.

A break in service caused by a termination can be bridged if the termination was due to a reduction in force and the employee returned to active full-time service with JHU less than one year from the date of termination. A break in service caused by a voluntary termination cannot be bridged for purposes of satisfying retiree eligibility criteria.

Your spouse or domestic partner and benefits-eligible dependent child(ren) are also eligible for coverage as long as they satisfy JHU’s eligibility rules for dependent coverage. Your family members are not eligible to participate in any coverage in which you are not enrolled (except as provided for surviving family members who are eligible to continue coverage following your death as described under “Changes in Coverage” on page 67). If you are eligible for retiree Medical benefit coverage, you may not add dependents (other than a newly acquired dependent added through a HIPAA special enrollment) to your retiree Medical benefit coverage after your initial enrollment.

* Retiree eligibility, including good standing and service requirements, shall be determined in the sole and exclusive discretion of JHU. Full-time service in a Visiting position will not be counted toward the retiree eligibility service criteria. Employment at a partnership organization, such as the Howard Hughes Medical Institute, as determined in the exclusive discretion of the University and as may be amended from time, may be counted towards the retiree eligibility service criteria.

**Must qualify for coverage under the JHU Domestic Partner Benefits Policy, as described in Eligibility and Enrollment on page 13.

How to Enroll

At least three months prior to retirement you should notify the Benefits Service Center of your intent to retire and arrange to meet with one of the retirement specialists. They will provide you with the necessary information and paperwork to enroll in retiree health insurance. For those that don’t meet with a retirement specialist, enrollment paperwork will be mailed out once the retirement termination has been processed.

If you want to elect retiree medical and/or dental benefits, you must actively enroll within 30 days of retirement. You will not be required to provide a Statement of Health. Because your coverage as an active employee ends the last day of the month in which you retire, there will be no “gap” in your coverage.
If you decide to enroll in retiree medical or dental coverage, you may elect individual coverage or you may elect to cover yourself plus any spouse, domestic partner or child who is eligible for the same coverage at that time.

If you decide to waive medical or dental coverage at retirement because you have coverage elsewhere (excluding Medicare), you will have the opportunity to enroll at a later date if you lose that alternative coverage. See “Changes in Coverage” below.

**Changes in Coverage**

If you drop (or waive) retiree medical or dental coverage for yourself or any eligible family member because of alternative coverage and you wish to enroll yourself or any affected eligible family member in the JHU retiree medical or dental coverage on a later date, you must provide proof of loss of the alternative coverage and you must request enrollment within 30 days after alternative coverage ends.

If you marry or enter into a domestic partnership while enrolled in retiree coverage, you will have the opportunity to enroll your new spouse or domestic partner and any eligible dependent child in the medical or dental plans in which you are currently participating within 30 days following the marriage or domestic partnership.

At the time of enrollment, your health coverage rate will follow the current rate structure.

**Discontinuing Retiree Health Plan**

If you enroll at retirement and you later wish to discontinue retiree medical or dental coverage, you must notify the Benefits Service Center in writing. If at any time you (or your surviving family member following your death) fail to make a payment for coverage within 30 days of the payment due date, that coverage will be automatically dropped retroactive to the last day of the previous month.

**Your Costs**

JHU contributes toward, or subsidizes, the cost of retiree medical coverage in varying amounts depending upon the age of the retiree, length of service and year of retirement.

*If you are an eligible retiree who retired before 2006, different rules apply in determining if you are eligible for a subsidy for medical coverage.*

Retirees who enrolled in retiree coverage and retired in 2006 or later must meet the “Rule of 75” to be eligible for a medical premium subsidy from JHU. This means that if the covered retiree’s age and eligible service (when added together) equals or exceeds 75, JHU will subsidize a fixed amount of the retiree medical premium costs annually. If age and service is less than 75, the covered retiree is not eligible for the subsidy, and must pay the full premium cost for coverage. If age and service equals or exceeds 80, the covered retiree is eligible for the maximum subsidy.
Medical Subsidy Paid by JHU

<table>
<thead>
<tr>
<th>Age Plus Service</th>
<th>% of Medical Premium Subsidy* Paid by JHU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 75</td>
<td>None—participant pays full premium cost</td>
</tr>
<tr>
<td>75</td>
<td>25%</td>
</tr>
<tr>
<td>76</td>
<td>40%</td>
</tr>
<tr>
<td>77</td>
<td>55%</td>
</tr>
<tr>
<td>78</td>
<td>70%</td>
</tr>
<tr>
<td>79</td>
<td>85%</td>
</tr>
<tr>
<td>80 or more</td>
<td>100% of maximum subsidy</td>
</tr>
</tbody>
</table>

* Note: See the following table for maximum subsidy amounts.

The table that follows shows the maximum subsidy amount JHU will pay toward medical coverage. The subsidy changes when the covered retiree becomes Medicare-eligible and does not adjust should the covered retiree’s spouse become Medicare-eligible first. Keep in mind that because the subsidy is a fixed amount, the covered retiree’s share of the retiree medical premium will grow over time as medical premiums increase.

JHU Contribution — Maximum Subsidy Amount*

<table>
<thead>
<tr>
<th></th>
<th>Not Medicare-Eligible</th>
<th>Medicare-Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,496 per year</td>
<td>$1,812 per year</td>
</tr>
<tr>
<td>Two Adults</td>
<td>$4,992 per year</td>
<td>$3,624 per year</td>
</tr>
</tbody>
</table>

* Age plus service must equal 80 or more to receive the maximum subsidy. See prior table for percentages of maximums actually provided as subsidy.

Please note that JHU reserves the absolute and exclusive right and discretion to make changes to the Retiree Health Plan, including terminating the Plan, or to make other change its contribution and the subsidy amounts at any time.

Medical premium costs vary by plan (e.g., CareFirst BlueCross BlueShield Medical, EHP Classic, CareFirst HDHP) and coverage level (e.g., Individual, 2 Adults). Premium costs change each year based on claims experience but the subsidy remains a fixed amount. Thus, covered retirees are responsible for any future increases in premium costs.

If you qualify for and timely elect the retiree medical and dental coverage, you will be billed monthly for your portion of the cost of the benefits by JHU’s billing service.
Example—Calculating the Cost of Coverage

Let’s say that you are single, considering retirement and are 62 years old with 15 years of continuous full-time service. Here’s how to calculate the cost of your medical premium:

**Step 1:** Your age + service = 62 + 15 = 77.

**Step 2:** Table 1 indicates that you are eligible for 55% of the maximum subsidy amount from JHU.

**Step 3:** 55% x $2,496/year (from Table 2, individual coverage, non-Medicare-eligible) = $1,372.80/yr. = JHU’s share of your premium.

**Step 4:** The 2022 retiree medical premium for individual coverage under the CareFirst BlueCross BlueShield Medical is: $14,529.12/yr.

**Step 5:** Your cost of coverage is equal to the difference between the 2022 retiree medical premium ($14,529.12) and JHU’s share of your premium ($1,372.80): $13,156.32/yr.

So, the amount JHU will pay toward your medical premium annually is $1,372.80. You will be responsible for paying the remaining cost of your medical premium, which is $13,156.32/yr.

**When Prior Service Counts Toward Medical Subsidy**

If you leave JHU and return, you must meet the eligibility requirements stated above, including having 10 or more years of continuous full-time service after reaching a minimum age of 55.

For your previous service to count toward the medical subsidy, your prior service must be in blocks of 10 or more years of continuous full-time service.

**If You Have Other Health Care Coverage**

If you or your eligible dependents have any other health coverage, JHU’s retiree medical benefits will coordinate with other plans to prevent duplication of payment. Read more about how coordination of benefits works in *Medical Coverage* on page 34.

**Effect of Medicare**

You and your dependents should enroll in Medicare as soon as possible. *JHU’s medical coverage for retirees and their dependents is automatically coordinated with benefits provided by (or that would be provided by if the individual enrolled) Medicare Parts A and B whether or not the covered individual has enrolled.* Once you or an individual covered through you becomes eligible for Medicare, Medicare is treated as the primary plan (pays benefits first). JHU’s retiree medical coverage then pays any remaining covered expenses beyond what is paid (or would be paid) by Medicare Parts A and B, up to the plan’s eligible allowable expense.

Once you are eligible for Medicare, you are also eligible to enroll in a Medicare Prescription Drug plan (also known as Medicare Part D), which is an optional plan that provides prescription drug benefits. While you are covered under the retiree medical coverage, you will receive a notice from JHU each year that lets you know whether JHU’s prescription drug benefits are at least as good as the standard Medicare Part D benefits.
Filing Claims for Benefits

Until you become eligible for Medicare, you should file claims as described in the plan materials listed in the Appendix on page 148 and in Administrative Information on page 115. Once you become eligible for Medicare, however, your medical claims will be processed as if they were submitted to Medicare first, so you should enroll in Medicare Parts A and B as soon as possible. Any claims that Medicare does not or would not cover in full may be submitted to JHU’s retiree medical plan for processing (and payment on a secondary basis to the extent that the expenses are covered under the terms of the plan).

If You Are Rehired

If, at any time, you are rehired by JHU as a full-time benefits-eligible employee, you will no longer be eligible for retiree health benefits. Instead, you will be eligible to participate in the myChoices Program. You must re-enroll in the retiree health coverage when your full-time employment again terminates if you wish to continue your health coverage under JHU’s Retiree Health Plan. Current rates will apply.

If you are rehired by JHU as a part-time or limited-time employee, and you choose to remain enrolled in JHU’s Retiree Health Plan, and you are eligible for Medicare, then Medicare will remain primary coverage and the JHU’s Retiree Health Plan will remain secondary coverage.

When Coverage Ends

Your retiree coverage will terminate on the earliest of the following dates:

- The date that your coverage is terminated by amendment of JHU’s Retiree Health Plan, by whole or partial termination of the Plan, termination of the insurance contract or agreement, or by discontinuance of contributions by JHU;
- The date you return to work as a full-time JHU employee (see “If You Are Rehired” on page 70); or
- The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due.
- If you die while covered under retiree coverage, your covered spouse or domestic partner is eligible to remain enrolled in JHU’s retiree medical or dental plans for their lifetime.
  - However, if he/she re-marries or begins a domestic partnership, the new spouse or domestic partner would not be eligible to enroll in the plans.
  - Your covered child(ren) may remain in the plans until they no longer meet the plan’s dependent eligibility requirements.
- For all other circumstances, coverage for your spouse and other dependents (including your domestic partner) terminates when your coverage terminates.
If you or your spouse or child ceases to be eligible to remain on JHU’s retiree medical and dental plans because of your divorce or separation or a loss of dependent status or if your child ceases to satisfy the eligibility requirements for dependent coverage (or in certain other cases), your covered dependents may be able to choose to continue medical and dental coverage under COBRA. Whenever this is applicable, COBRA information and enrollment instructions will be sent to your home address or to the address that is provided.

Note that JHU reserves the right to amend the Retiree Health Plan, and all component retiree medical and dental plans, in whole or in part or to completely discontinue the Plan at any time (see “About This Handbook” on page 7). JHU will set the level of contributions required by retirees annually, and that level may be changed at any time.
Vision Plan

If you wear eyeglasses or contacts, you know how expensive vision care can be. JHU recognizes this and offers its employees the opportunity to purchase vision care coverage through EyeMed Vision Care (EyeMed) to help you with those expenses.

The vision plan gives you the opportunity to receive coverage and/or discounts on eye exams, eyeglasses, contact lenses and laser vision correction when you receive services from an EyeMed-participating provider. You can also receive reimbursement, up to certain limits, for services you receive from a non-participating provider.

Vision at a Glance

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>EyeMed Vision Plan (In-network benefits)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eye Exam</strong></td>
<td>You pay $10 copay (once yearly)</td>
</tr>
<tr>
<td><strong>Lenses (single vision, lined bifocal, lined trifocal, lenticular)</strong></td>
<td>You pay $20 copay (once yearly)</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>$150 allowance (once yearly)</td>
</tr>
<tr>
<td><strong>Contact Lenses (in lieu of frames and lenses)</strong></td>
<td>$150 allowance for elective contact lenses 100% (plan pays) for medically necessary contact lenses</td>
</tr>
<tr>
<td><strong>Laser Vision Correction</strong></td>
<td>15% discount</td>
</tr>
</tbody>
</table>

How the Vision Plan Works

If you decide to participate in the vision plan, you will have access to a nationwide network of doctors who provide care and offer a wide selection of eye care materials.

Maximize Your Coverage with In-Network Providers

You have the option of receiving services from any eye care provider you choose. However, you receive a higher level of coverage and pay less out of your own pocket when you go to a provider who participates in EyeMed’s network.

When you make an appointment with a participating provider, identify yourself as an EyeMed member.
The provider will verify your eligibility and plan coverage. If eyewear is necessary, your doctor will coordinate your prescription with EyeMed.

You pay a $10 copayment for the exam at the time of your visit. EyeMed will pay the provider directly for the balance of covered services and eyewear up to the amount allowed under the vision plan. You are responsible for any additional costs resulting from balances beyond the covered allowance, cosmetic options or noncovered services and eyewear.

**Out-of-Network Providers**

When you go to a provider who does not participate in the EyeMed network, you will pay more out-of-pocket for eye care services and materials.

If you receive services from a non-EyeMed provider, you will need to pay the provider in full at the time of service and submit a claim to EyeMed for reimbursement.

**Cost of Coverage**

You pay the full cost of EyeMed vision plan coverage.

**What’s Covered, for How Much?**

See your plan summary included in the *Appendix* on page 148 for a complete list of covered services under the vision plan. Some highlights include:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eye Exam</strong></td>
<td>You pay $10 copay (once yearly)</td>
<td>Covered up to $40</td>
</tr>
<tr>
<td><strong>Lenses</strong></td>
<td>You pay $20 copay (once yearly)</td>
<td>Covered up to $40 – $80 depending on lens type</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>$150 allowance (once yearly)</td>
<td>Covered up to $66</td>
</tr>
<tr>
<td><strong>Contact Lenses (in lieu of frames and lenses)</strong></td>
<td>$150 allowance for elective contact lenses 100% (plan pays) for medically necessary contact lenses</td>
<td>Covered up to $150 for elective lenses; up to $210 for medically necessary contact lenses</td>
</tr>
<tr>
<td><strong>Laser Vision Correction</strong></td>
<td>15% discount</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
**What’s Not Covered**

See your plan summary included in the *Appendix* on page 148 for a list of services that are not covered under the vision plan.

**Discount Details**

The plan provides a variety of member discounts on certain services available through network providers. See your plan summary included in the *Appendix* on page 148 for more details.

**Filing Claims for Benefits**

You must file claims for out-of-network care under the EyeMed vision plan. For in-network care, your vision provider will complete and submit the claim forms.
Health Savings Account (HSA)

If you enroll in JHU’s CareFirst BCBS High Deductible Health Plan (HDHP), you may be eligible to participate in a special tax-advantaged Health Savings Account (HSA) that allows you to set aside funds on a pre-tax basis to help fund your out-of-pocket costs.

If you earn $60,000 or less a year, JHU will add a contribution to your HSA. Unlike the Flexible Spending Accounts (FSAs), all of your HSA funds roll over from year to year — so you can spend them now or save them for later.

Your HSA is not an ERISA plan.

HSA at a Glance

<table>
<thead>
<tr>
<th>Health Savings Account</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who Can Participate?</strong></td>
</tr>
<tr>
<td><strong>Who Can Contribute?</strong></td>
</tr>
<tr>
<td><strong>How Much Can You Contribute?</strong></td>
</tr>
<tr>
<td><strong>How It Works</strong></td>
</tr>
</tbody>
</table>
Eligibility and Enrollment

To be HSA-eligible, you:

- Must be enrolled in the CareFirst High Deductible Health Plan (HDHP) medical plan. This medical plan is considered a qualified high-deductible health plan (HDHP).
- Must not be enrolled in other impermissible coverage. For example, you can’t be covered under a non-HDHP (such as a spouse’s health plan) or have a general purpose Health Care FSA.
- Must not be enrolled in Medicare. (Note that if you are receiving Social Security, you may be automatically enrolled in Medicare Part A. If that is the case, you are not eligible to contribute/receive HSA contributions.)

When you enroll in the HDHP medical option, you will automatically be enrolled in the HSA.

The HSA and the Health Care FSA

It’s important to note that you cannot participate in both the HSA and a general-purpose Health Care FSA. A general-purpose Health Care FSA is impermissible coverage, which makes you ineligible to contribute/receive HSA contributions. (Note: If your spouse has a Health Care FSA that covers you, that too is impermissible coverage.)

However, a new Limited Purpose FSA will be available only for HDHP participants. The Limited Purpose FSA can be used for eligible dental and vision expenses only. The maximum contribution limit is the same as under the general-purpose Health Care FSA limit ($2,850 in 2022). Consider participating in both the HSA and Limited Purpose FSA to maximize your savings and tax benefits.

How the HSA Works

You contribute to your account through payroll deductions on a pre-tax basis. You can make a tax-free withdrawal up to the balance available in your account to cover qualified medical expenses. You may also use your account to pay for other expenses, although withdrawals for such expenses are subject to federal, state, and local taxes, as applicable, and in most cases a 20% penalty tax. Any unused balance in your account at year-end remains in your account.

Advantages of the HSA

JHU Contributions — In 2022, if you earn $60,000 a year or less, JHU will make a contribution to your HSA to help offset the higher deductible. The amount of the annual contribution will depend on your pay band as follows:

- If you earn $40,000 or less annually: $500 Single / $1,000 Family;
- If you earn between $40,001 and $60,000 annually: $250 Single / $500 Family
The JHU contribution will be fully funded in January 2022 following Annual Enrollment, provided that you have established your HSA. If you have not established your HSA by the date of the January distribution, JHU will make the contribution at a later date if you are (1) an active employee, and (2) you establish your HSA within 60 days of your initial enrollment. Otherwise, you will not receive your HSA contribution from JHU. JHU reserves the right and absolute discretion to make changes to the income thresholds eligible to receive HSA contributions or the contribution amounts at any time.

If you are newly eligible for the HSA sometime after Annual Enrollment, the JHU contribution will be prorated.

**You Can Contribute Pre-Tax Dollars**—In addition, you can contribute to your HSA on a pre-tax basis: In 2022, you can contribute up to $3,650 per individual and up to $7,300 per family (including the JHU contribution). These contribution limits are reduced by any JHU contribution to your HSA. You can adjust your contribution amount anytime throughout the year. From age 55 until you are eligible for Medicare, you can contribute an additional $1,000 annually.

**The HSA is Triple-Tax-Advantaged** — Contributions to the account are tax-free. Funds, and any applicable dividends or interest, accumulate tax-free. Distributions used for qualified medical expenses are tax-free.

**The HSA Is Yours and It Is Portable** — Unlike the FSA, unused funds in your HSA roll over from year-to-year. With the HSA, you can choose to use funds now to pay for eligible expenses, or to set aside funds on a pre-tax basis for future use. The choice is yours! It allows you to maximize your savings for when you need it most.

In addition, once your HSA balance reaches $1,000, you can choose how to invest your funds—so they can grow over time. And, if you leave JHU, you can take your HSA with you.

Think of it as a savings tool for your short- and long-term future. You can use your HSA funds to pay for eligible medical, prescription drug, dental, vision and other health care expense that you incur today — or later in life.

### Managing and Investing Your Account

After you reach the $1,000 investment threshold, you have the option of moving your HSA funds from a cash account to an interest-bearing account in $100 increments. At any time, you may also invest funds from your interest-bearing account into a wide variety of mutual funds.

WEX will provide enhanced resources, tools and payment options for added convenience.
Whose Expenses Are Eligible?

According to the IRS, a qualifying family member includes any person who qualifies for tax-free health plan benefits, including any of the following individuals:

- your spouse
- a person for whom you can claim an exemption on your federal taxes
- a person who meets all of the following criteria:
  - is your child (by birth or adoption), stepchild or foster child; your sibling or, step-sibling; or the descendant of your child, stepchild, foster child or sibling
  - lives with you for more than half the year
  - doesn't provide more than half their own support for the year
  - is your dependent for tax purposes
  - is either a US citizen, national, or resident; a resident of Canada or Mexico; or a child being adopted by a US citizen or national who shares that individual's home as a member of the household
- another person (e.g., relative, domestic partner, same-sex spouse) who meets all of the following criteria:
  - receives more than half of their support from you during the calendar year
  - can't be claimed as anyone's "qualifying child" dependent
  - is your relative or, if the person is not your relative, he or she must live with you for the entire calendar year as a member of your household (except for temporary reasons such as vacation, military service or education) and the relationship cannot be in violation of local law
  - is either a US citizen, national, or resident; a resident of Canada or Mexico; or a child being adopted by a US citizen or national who shares that individual's home as a member of the household

You can make withdrawals for eligible expenses for you, your spouse or your qualifying family members.

Unless your domestic partner and their children qualify for tax-free health plan benefits (as described above), the federal government does not permit you to use your Health Savings Account for eligible expenses incurred by your domestic partner or their children.

What Expenses Are Eligible for HSA Withdrawal

You can withdraw money from your HSA for any reason, but only distributions for qualified medical expenses are tax-free. Generally, qualified medical expenses must cover medical care as defined by Section 213(d) of the Internal Revenue Code, which includes the treatment, diagnosis, cure mitigation or prevention of disease and any related equipment, supplies, and diagnostic devices.
To view which health care expenses may be eligible, go to [www.irs.gov](http://www.irs.gov) to view IRS Publication 502. You can also view the eligible expense list on the WEX website at [www.wexinc.com](http://www.wexinc.com). For example, covered expenses could be medical copayments and coinsurance, dental or vision expenses, etc. You may also use your account to pay for the following insurance premiums:

- COBRA premiums
- Long-term care insurance
- Medicare premiums

It’s your responsibility to determine which expenses are eligible for tax-free withdrawal once you open your account.

## What Expenses Are NOT Eligible for HSA Withdrawal

The following are examples of expenses that would not qualify for a tax-free withdrawal from your Health Savings Account. Note that you can withdraw from your HSA to pay for such items, it’s just that you will be taxed on the withdrawal (and a penalty may apply).

- contributions to other employer-sponsored dental, vision or medical plans, including plans sponsored by your spouse’s employer (your contributions to JHU’s dental, vision and medical plans are already made on a pre-tax basis)
- Medigap premiums
- costs you deduct as qualified medical expenses on your federal income tax return
- over-the-counter non-prescription medicines without a prescription
- expenses reimbursed by any other health plan
- health/gym/fitness club membership fees
- elective cosmetic surgery: electrolysis, hair removal or transplants, liposuction, etc.
- vitamins and other dietary supplements, toiletries and cosmetics that are not medically necessary
- medications purchased merely to maintain you or your family’s health
- prescription drugs that are not medically necessary and not permitted by the IRS (such as Rogaine)
- cosmetic dental work (including bleaching, bonding and veneers)
- undocumented travel to or from your physician's office or other medical facility
- weight loss programs (unless you have a letter from your treating physician indicating medical necessity)
Using Your WEX Debit Card

When you or your eligible dependent has a qualified medical expense that isn’t covered by your medical or prescription drug plan, you can pay for the expense using your WEX debit card. If you pay out of pocket for that expense, you may also reimburse yourself from your HSA at a later time. To do this self-reimbursement, you can direct deposit funds from your HSA to your personal banking account. As long as your qualified medical occurred on or after your HSA was established, you may reimburse yourself at any time. Please retain your itemized EOB or provider documentation for your records when using your HSA for any qualified medical expense. Claim forms are available online at www.wexinc.com.
Health Care and Limited Purpose Flexible Spending Accounts (FSAs)

The Health Care Flexible Spending Account (FSA) allows you to set aside pre-tax dollars to use for eligible health and/or dependent care expenses. While HDHP participants will not be HSA-eligible if they participate in a general purpose Health Care FSA, a Limited Purpose FSA is offered to pair with an HSA. The Limited Purpose FSA can be used to pay for eligible dental, vision and preventive care expenses only.

### Health Care FSA at a Glance

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

<table>
<thead>
<tr>
<th>Health Care Flexible Spending Account</th>
<th>Limited Purpose Flexible Spending Account (for HDHP participants only)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Why Participate</strong></td>
<td>To save on taxes by paying for eligible expenses with pre-tax dollars.</td>
</tr>
<tr>
<td><strong>What’s Reimbursed?</strong></td>
<td>For participants in the High Deductible Medical Plan (HDHP) only. Out-of-pocket dental and vision expenses not reimbursed by your health care plans and considered deductible by the IRS. For example:</td>
</tr>
<tr>
<td></td>
<td>• Dental plan deductibles, co-insurance and copayments;</td>
</tr>
<tr>
<td></td>
<td>• Prescription eyeglasses and hearing aids; and/or</td>
</tr>
<tr>
<td></td>
<td>• Orthodontic expenses.</td>
</tr>
<tr>
<td></td>
<td>For example:</td>
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<tr>
<td></td>
<td>• Medical and dental plan deductibles, co-insurance and copayments;</td>
</tr>
<tr>
<td></td>
<td>• Prescription eyeglasses and hearing aids; and/or</td>
</tr>
<tr>
<td></td>
<td>• Orthodontic expenses.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Ineligible Expenses</th>
<th>Limited Purpose FSA Benefits</th>
<th>Filing Claims for Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>82</td>
<td>85</td>
</tr>
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<td></td>
<td>85</td>
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</tr>
</tbody>
</table>
Health Care and Limited Purpose Flexible Spending Accounts (FSAs)

<table>
<thead>
<tr>
<th>Health Care Flexible Spending Account</th>
<th>Limited Purpose Flexible Spending Account (for HDHP participants only)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How Much You Can Contribute</strong></td>
<td>Up to $2,750 each year.</td>
</tr>
</tbody>
</table>
| **Claims/"Use or Lose It" rule**      | ▪ Generally, your claims must be incurred by December 31. You have until April 30 of the following year to submit your claims.  
▪ If you have at least $30 in your account as of December 31, then up to $550 in unused contributions will automatically be carried over to the next calendar year and can be applied to eligible expenses in that year.  
▪ All amounts over $550 that remain in your FSA after April 30 claim are forfeited—this is the "use it or lose it" rule. |

**Limited Purpose FSA**

It's important to note that you cannot participate in both the Health Savings Account (HSA) and a general-purpose Health Care FSA. However, the Limited Purpose FSA is available only for HDHP participants. The Limited Purpose FSA can be used for eligible dental, vision and preventive care expenses only. The maximum contribution limit is the same as under the general-purpose Health Care FSA limit. Consider participating in both the HSA and limited purpose FSA to maximize your savings and tax benefits.

**How You Save**

The Health Care FSA and Limited Purpose FSA allow you to set aside pre-tax dollars from your pay through automatic payroll deductions to use toward eligible expenses. Because your contributions are deducted from your pay before taxes are withheld, you will lower your taxable income and benefit from tax savings. When you have an eligible health care expense, you will pay using your WEX debit card or you may submit a claim after the service.

**How to Enroll**

During the annual enrollment period (or when you first become eligible), you decide whether to participate and how much money to contribute for the coming year.

You may contribute up to $2,850 in 2022. Throughout the year, JHU deducts contributions from your pay in equal amounts each pay period before FICA (Social Security and Medicare taxes); federal and Maryland income taxes are deducted.

Plan Carefully

Be sure to estimate expenses for the year before you decide how much to contribute, since the “use it or lose it” rule applies. See “Use It or Lose It” on page 83.
Pay Your Expenses

When you pay an eligible expense, save your receipt, regardless of whether you are using a WEX debit card, the pay my provider service, online claim filing, mobile app, or traditional claims forms.

File Claims

File a claim to be reimbursed for your out-of-pocket expenses not paid using your WEX debit card or pay my provider service. Expenses paid with the WEX debit card and using pay my provider are paid directly from your FSA.

Receive Tax-Free Reimbursement

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

Use It or Lose It

Your request for reimbursement must be filed by April 30 of the following plan year. If your Health Care FSA or Limited Purpose FSA has a balance after April 30 of the following plan year, up to $550 in unused contributions will automatically be carried over. The unused balance cannot be cashed out. Any funds over $550 remaining in your account after April 30 of the following plan year will be forfeited. With this "use it or lose it" rule, it is important that you plan your contributions carefully.

If you elect HDHP medical coverage for the subsequent plan year, any amounts carried over will automatically be moved into a Limited Purpose FSA.

Whose Expenses Are Eligible?

You may use your Health Care FSA to pay for eligible expenses of:

- Your spouse;
- Your children until the end of the year in which they turn age 26, regardless of student status, whether they are married or live with you and regardless of whether you provide any support;
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support; and
- Any other person (including a domestic partner) who meets the IRS definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child (as defined under the Internal Revenue Code) of the employee or any other individual. (Note, an employee can treat another person’s qualifying child as a qualifying relative if the child satisfies the other requirements listed here and if the other person isn’t required to file a tax return and either doesn’t file a return or files one only to get a refund of withheld income taxes. For example, this could allow tax-free health coverage for the children of an employee’s non-working domestic partner.)
Please note: Domestic partners and their children are eligible for coverage under JHU’s medical and dental plans. However, under federal tax law, a Health Care FSA may not be used for expenses of domestic partners or their children, unless they qualify as your eligible dependent under the specific federal tax law definitions that apply to Health Care FSAs.

## What Expenses Are Eligible?

Here is a partial list of expenses that may be eligible for reimbursement under the general purpose Health Care FSA:

- **Medical Expenses**
  - Deductibles, coinsurance and copayments
  - Charges for routine check-ups, physical examinations, and tests connected with routine exams
  - Charges over the “reasonable and customary” limits
  - Expenses excluded under the terms of the Medical benefit plan
  - Drugs requiring a doctor’s written prescription that are not covered the Medical benefit plan
  - Over-the-counter drugs, if obtained with a prescription, and only as permitted under applicable law or regulation. Certain other over-the-counter items such as bandages, crutches, and other supplies will be reimbursable without a prescription, but only to the extent applicable regulations permit
  - Insulin (which may be reimbursed without a prescription)
  - Smoking cessation programs and related medicines (if the medicines require a prescription)
  - Weight loss programs which are at the direction of a physician to treat a medical condition such as hypertension (weight loss programs for general health improvement do not qualify)
  - Other selected expenses not covered by a medical plan that qualify for a federal income tax deduction, such as special services and supplies for the disabled (such as seeing eye dogs for the blind, dentures and artificial limbs, wheelchairs and crutches).

- **Dental Expenses**
  - Deductibles, coinsurance and copayments
  - Expenses that exceed the maximum annual amount allowed by your dental plan
  - Charges over the “reasonable and customary” limits
  - Orthodontia treatments that are not strictly cosmetic

For a Detailed List of Eligible Expenses

Vision and Hearing Expenses

- Vision examinations and treatment not covered by a vision plan
- Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner
- Cost of hearing exams, aids and batteries

Transportation — Amounts paid for transportation for health care can be claimed. Transportation costs do not include the cost of any meals and lodging while away from home and receiving health care treatment.

Ineligible Expenses

For a list of ineligible expenses, refer to IRS Publication 502: Medical and Dental Expenses at www.irs.gov.

Limited Purpose FSA Benefits

If you are participating in the CareFirst HDHP and are contributing to an HSA, you are only eligible to participate in the Limited Purpose FSA. Generally, the Limited Purpose FSA operates just like the Health Care FSA described in the prior section, with a few important exceptions:

- You may obtain reimbursements only for:
  - Dental care expenses
  - Vision care expenses
  - Preventive care expenses
- Medical expenses that are not dental, vision and/or preventive care expenses are not considered eligible expenses.

Here is a partial list of dental and vision expenses that are eligible for reimbursement, to the extent they are not otherwise covered by your health plan(s):

- Vision care expenses
  - Eyeglasses
  - Prescription sunglasses
  - Contact lenses and supplies
  - Ophthalmologist fees
  - The cost of a guide dog for the blind and special education devices for the blind (such as an interpreter)
  - Laser surgery

For a Detailed List of Eligible Expenses
Dental care expenses
- Anesthesia
- Cleaning
- Charges in excess of Usual and Prevailing Fee Limits
- Drugs and their administration
- Experimental procedures
- Extra sets of dentures or other dental appliances
- Medically necessary orthodontia expenses for adults or dependents
- Myofunctional therapy
- Replacement of dentures or bridgework
- Replacement of lost, stolen, or missing dentures or orthodontic devices

Filing Claims for Benefits

WEX Debit Card

If you elect to participate in the Health Care FSA or Limited Purpose FSA, you are automatically issued a WEX debit card to use when paying for eligible expenses. When you use your debit card, you agree to be bound to all the applicable terms and conditions, including substantiation requirements, as discussed in detail below.

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

Your WEX debit card is active upon arrival. Most forms of communication from WEX will be sent to you via email, so please be sure your preferred email address is on file with JHU. If you would prefer to receive paper statements, you can elect to do so at any time by logging in, selecting the FSA, and then choosing View Account Statement.

The following are some guidelines you are required to follow when using your debit card:

- **Keep your receipts.** It is important to be aware that flexible spending account debit card transactions are subject to all applicable IRS rules and regulations governing their usage. WEX may ask you to provide copies of your receipts to “substantiate” your purchase to prove that the expense is eligible under the plan. In all cases, you must be prepared to submit a photocopy of your receipts. If substantiation is requested by WEX and you fail to provide it in a timely manner, your debit card will be deactivated.
Buy from qualified or IIAS-certified merchants. When using your WEX debit card at IIAS-certified merchants, you will not be required to submit receipts to WEX. If you purchase items from merchants that are not IIAS-certified, you will be required to provide additional documentation, including a description of the expense, date, amount, and a receipt. A list of the certified merchants can be found at www.sig-is.org (click on SIGIS Merchant List under Publications).

Use the card only for qualified medical expenses. Whenever you make purchases at an IIAS-certified merchant, the store’s system checking inventory control compares the stock-keeping units (SKU) number for your entire purchase against the SKUs from a list of items that qualify as medical expenses. If you purchase items that qualify as medical expenses at the same time you purchase items that do not qualify as medical expenses, you will be asked for additional payment to purchase the remaining non-medical items.

Traditional Claims Reimbursement
For traditional claims reimbursement, complete a Claim Form available at www.wexinc.com. Attach supporting proof of your expenses. This proof could be an itemized bill from your health care provider showing:

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

Provider signature is not required, but can replace need for other proof of service. You can also submit claims online by logging into your account with WEX at www.wexinc.com. You may change your method of reimbursement at any time during the year, regardless of your initial choice, by updating your online profile with WEX at www.wexinc.com. If you do not have online access, you can call WEX at 866-451-3399 to update your method of reimbursement for you.

When Your Employment Ends
Unless you elect to continue your Health Care FSA or Limited Purpose FSA under COBRA (see “COBRA General Notice” on page 26), your coverage ends on your date of termination of employment. Only claims incurred on or before your date of termination may be reimbursed. All claims must be submitted to the Claims Administrator within 120 days after your date of termination. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.
Disability Coverage

JHU provides valuable disability coverage to provide financial protection in the event that you are unable to work due to a disability. Your coverage includes both short-term and long-term disability protection.

See your plan summary included in the Appendix on page 148 for additional information about your Disability coverage.

Benefits at a Glance

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Short-Term Disability</th>
<th>Long-Term Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When benefits begin</strong></td>
<td>After 14 consecutive days (your “elimination period”), during which you have been unable to work due to an illness or injury, as defined in “How STD Benefits Work.”</td>
<td>After 90 consecutive days (your “elimination period”), during which you have been unable to work due to an illness or injury and are considered disabled, as defined in “How LTD Benefits Work.”</td>
</tr>
<tr>
<td><strong>Amount you are paid</strong></td>
<td>60% of your pre-disability weekly earnings, to a maximum weekly benefit of $2,500.</td>
<td>60% of your pre-disability monthly earnings, to a maximum monthly benefit payment of $10,000.</td>
</tr>
<tr>
<td><strong>Your cost for this benefit</strong></td>
<td>You pay the full cost for this benefit.</td>
<td>JHU provides this benefit at no cost to you.</td>
</tr>
</tbody>
</table>
How Short Term Disability Benefits Work

STD benefits begin if an illness or injury prevents you from working for more than 14 consecutive days. Starting on the 15th day of your absence, benefits are payable for a maximum of 11 weeks, but only while you remain disabled.

For the purposes of STD coverage, you are “disabled” if Lincoln Financial Group determines that:

▪ You are unable to perform the material and substantial duties of your regular occupation; and
▪ You are not being paid to work in any occupation for which you are qualified by education, training or experience.

You are not considered disabled if you are able to earn 80% of your pre-disability income.

To be approved for STD benefits, you must provide medical documentation from your physician or health care provider showing that you are disabled once you have been absent for 14 consecutive days. Any accrued paid sick or other leave will be used during the 14-day elimination period.

While you are disabled, after the 14-day elimination period, STD benefits provide you with 60% of your pre-disability weekly pay, excluding commissions, bonuses and overtime, as well as any payments you receive under workers’ compensation, with a maximum weekly STD benefit of $2,500. Your STD benefits will be reduced by any payments you receive under an occupational disease act or law, or under a statutory disability benefit.

A claim overpayment can occur when you receive a retroactive STD payment, when Lincoln Financial Group inadvertently makes an error in the calculation of a claim, or if fraud occurs. Claim overpayments are amounts paid to you in excess of what should have been paid under the plan. In an overpayment situation, you will be required to make a full repayment for any claim overpayments.

Recurring Disabilities

If your disability ends but recurs due to the same or a related cause less than 15 days later, it will be considered a resumption of the prior disability. In that case, benefit payments will not be subject to a new elimination period and a single 11-week payment period will apply to both periods of disability combined.

If your disability recurs 15 or more days after the end of a prior disability, it is treated as a new disability and subject to a separate elimination period, as well as a new 11-week maximum payment period.
**STD Work Incentive Benefit**

If you are disabled but can work in some capacity, you may be approved for work incentive benefits. This allows you to receive a portion of your STD benefits while you work, provided you earn less than 80% of your pre-disability earnings. Work incentive benefits are equal to your regular STD benefit, minus any amount that when combined with your work earnings would exceed 100% of your pre-disability weekly earnings.

**How Long-Term Disability Coverage Works**

If you are disabled and unable to work due to an illness or injury, long-term disability (LTD) benefits generally pay 60% of your pre-disability monthly earnings to a monthly maximum benefit of $10,000. You are not considered disabled if you are able to earn 80% of your pre-disability income.

**Definition of “Disabled”**

For the purposes of LTD coverage, “disabled” is determined by Lincoln Financial Group and means:

- during the 90-day elimination period and the next 24 months of disability the covered person, as a result of injury or sickness, is unable to perform the material and substantial duties of his own occupation; and
- thereafter, the covered person is unable to perform, with reasonable continuity, the material and substantial duties of any occupation.

LTD benefits begin if you are disabled and unable to work after 90 consecutive days. After the 90-day elimination period, LTD benefits are paid at 60% of your pre-disability monthly earnings (to a monthly maximum of $10,000) until the earlier of:

- The date you are no longer disabled; or
- The date you reach age 65 (extended payment periods may apply if you become disabled on or after age 60).

Your pre-disability monthly earnings are your regular monthly earnings, excluding commissions, or overtime. The LTD benefits you receive will be reduced by any payments you receive from:

- Social Security;
- Workers compensation;
- Any payments under an occupational disease act or law;
- Any occupational accident coverage;
- A state teachers retirement system;
- Benefits under a statutory disability benefit law;
- The Railroad Retirement Act;
- The Canada Pension Plan, Québec Pension Plan, or Canada Old Age Security Act; or
- Any other public employee retirement system plan.
If benefits under certain programs listed above increase while you are receiving LTD benefits, your LTD benefit may not be further reduced based on that increase.

If you expect to become eligible for Social Security disability benefits, it is assumed that you will apply. Service representatives from Lincoln Financial Group are available to assist you in applying for and securing a Social Security disability award, at no charge to you.

The maximum payment period of LTD benefits depends on your age when you became disabled, as shown in the following table. Benefits will end earlier if you cease to be totally disabled or you fail to comply with any requirements to provide proof of your ongoing disability.

<table>
<thead>
<tr>
<th>Age When Your Disability Began...</th>
<th>Maximum Payment Period</th>
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<tbody>
<tr>
<td>Age 60 or younger</td>
<td>Until your 65th birthday.</td>
</tr>
<tr>
<td>Age 60 through 67</td>
<td>60 months or until your 70th birthday, whichever occurs first.</td>
</tr>
<tr>
<td>Age 68 or older</td>
<td>24 months.</td>
</tr>
</tbody>
</table>

**Recurring Disabilities**

If your disability ends but recurs due to the same or a related cause within six months of return to work, it will be considered a resumption of the prior disability. In this case, LTD payments will immediately resume at the initial payment amount with no adjustment for any pay increase you may have received.

If your disability ends and LTD payments stop, but the disability recurs due to the same or related causes six months (or later) of your return to work, the disability is treated as a new disability and is subject to:

- A new 90-day elimination period;
- A new maximum payment period; and
- Any other plan provisions in effect on the date your disability recurs.

**LTD Work Incentive Benefit**

If you are disabled but can work in some capacity, you may not be eligible for the full LTD benefit that you would receive if you were unable to work at all but you may be approved for work incentive benefits. Work incentive benefits are equal to a portion of the benefit you would receive if you qualified for full LTD benefits while you work, provided you earn less than 80% of your pre-disability earnings.

See your plan summary included in the Appendix on page 148 for information about how this benefit is calculated.

**Coordination with Family and Medical Leave (FMLA)**

If you are approved for leave under the Family and Medical Leave Act, your disability coverage will continue up to 12 weeks following the date of leave. If you do not return to work as scheduled in your agreement with JHU, your LTD coverage will be terminated.
Coordination with Medicare

If you are on disability, and you are receiving Social Security disability benefits, you generally will become eligible for Medicare after 24 months. At this time, Medicare will become your primary medical coverage until you return to active employment. Once you become eligible for Medicare, if your employment with JHU has terminated but you are still covered under JHU’s plan, benefits under JHU’s plan will be treated as secondary to Medicare. This is true even if you do not actually enroll in Medicare, so you should enroll in both Medicare Part A and Medicare Part B as soon as you become eligible. You should also know that you may pay a penalty if you do not sign up for Medicare when you first become eligible. If you have questions concerning Medicare, you should contact the Social Security Administration.

Additional Benefits and Services

See your plan summary included in the Appendix on page 148 for information about some additional benefits and services covered under the plan, including:

- Survivor Income Benefit
- Worksite Modification Benefit
- Vocational Rehabilitation Services

Features That Apply to Both STD and LTD Plans

Limitations and Exclusions

STD and LTD coverage does not cover any loss caused by, contributed to or resulting from:

- Attempted suicide, while sane or insane, or an intentionally self-inflicted injury or sickness;
- Occupational injury or sickness (STD only); or
- Commission of or attempt to commit a felony.

Benefits are not payable during any period in which you are confined in a penal or correctional institution, provided the period of confinement exceeds 30 days.

When Your Disability Coverage Ends

Your disability coverage will end on the earliest of:

- The date the plan is terminated;
- For STD coverage, if you fail to pay the required premium, the last day for which you have paid for coverage; or
- The date you retire or otherwise terminate employment with JHU.

If you cease work due to leave of absence or military leave, STD and LTD coverage will continue for three months after the date you last actively worked, subject to continued payment of the STD premium.
Filing Claims for Benefits

You should apply for STD benefits as soon as you are aware that your absence will extend beyond 14 days. You should apply for LTD benefits as soon as you know that your disability will extend beyond 90 consecutive days.

You apply for STD benefits by calling Lincoln Financial Group at 888-246-4483 to begin the claim process. If your claim is approved and you begin receiving STD payments, after 90 days your claim will be automatically transferred to the LTD claim area for handling, provided you are still disabled.

To apply for LTD benefits only, complete and return the Application for Long-Term Disability Income Benefits (available on the Benefits website at https://hr.jhu.edu/wp-content/uploads/Report-LTD-Claim.pdf) to the LTD insurance company:

Benefit Management Services
Lincoln Financial Group
100 Liberty Way, Suite 100
Dover, NH 03280-4695

When you apply for either STD or LTD benefits, you will need to provide proof of your disability. See your plan summary included in the Appendix on page 148 for additional details.

If proof of your disability is not provided within 30 days, your STD benefits may be suspended or terminated. For LTD benefits, proof of disability must be given no later than one year after the end of your 90-day elimination period, unless you are legally incapacitated. On a periodic basis, you may be asked to submit proof of your ongoing disability to Lincoln Financial Group. You are responsible for the cost of providing this information. In addition, Lincoln Financial Group has the right to have you examined, at its expense, as often as necessary while your disability claim continues.
Life Insurance benefits are provided under JHU’s employee benefit plan through the following coverage options:

- Basic life insurance;
- Supplemental life insurance; and
- Dependent life insurance.

AD&D is provided under JHU’s AD&D insurance plan. This coverage is available only to faculty and staff; it is not available for bargaining unit employees.

Business Travel Accident insurance is provided under JHU’s group travel insurance plan.

**Life and Accident Insurance at a Glance**

**Basic and Supplemental Life Insurance**

JHU provides you with basic life insurance coverage at no cost:

- If you are faculty or staff, you receive coverage of $10,000;
- If you are a bargaining unit employee, you receive coverage equal to your base annual salary, rounded to the next lower $1,000.

You have the opportunity to elect supplemental life insurance coverage:

- If you are faculty or staff, you have the option of electing one to eight times your annual earnings, rounded to the next higher $1,000 (to a maximum of $3,000,000 in total basic and supplemental coverage, minus the $10,000 of basic life insurance); or
- If you are a bargaining unit employee, you may elect supplemental life insurance coverage equal to 1x your base annual salary, rounded to the next lower $1,000 (to a maximum of $2,000,000 in total basic and supplemental coverage).
**Dependent Life Insurance**

If you are faculty or staff, you have two coverage options:
- $4,000 for your spouse or domestic partner, and $2,000 per child; or
- $10,000 for your spouse or domestic partner, and $5,000 per child.

If you are a bargaining unit employee, JHU pays for $4,000 in coverage for your spouse or domestic partner, and $2,000 per child.

**Accidental Death & Dismemberment Insurance**

JHU provides faculty and staff with $10,000 of basic AD&D coverage at no cost; and the option of elect one to eight times your annual earnings, rounded to the next higher $1,000, subject to a maximum of $3,000,000 (when combined with basic AD&D). Faculty and staff also have the opportunity to elect coverage for eligible spouse/domestic partner equal to 60% of their amount of additional AD&D insurance (when there are no eligible children), or 50% of their amount of additional AD&D insurance (when there are eligible children), subject to a maximum of $250,000. Faculty and staff can elect coverage for eligible children equal to 20% of their amount of additional AD&D insurance, subject to a maximum of $50,000.

**Bargaining unit employees are not eligible for AD&D insurance coverage.**

**Business Travel Accident Insurance**

JHU provides you with coverage at no cost:

- For accidental death, dismemberment, coma, & paralysis, the Principal Sum maximums are:
  - Full-time and part-time professional and faculty employees, staff members, and bargaining unit employees: three times Annual Salary to a maximum of $500,000
  - Spouse: $50,000
  - Dependent Child(ren): $25,000

- For Out-Of-Country Medical Expense benefits the maximum is: $150,000 per sickness or injury.

- For Emergency Medical Evacuation and Repatriation coverage, the maximum is: 100% of covered expenses.

- For Security Evacuation coverage, the maximum is: $100,000.
How Basic and Supplemental Life Insurance Works

Provided you are eligible, JHU provides basic life insurance coverage at no cost to you. Benefits are generally paid as a single lump sum.

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

You have the opportunity to elect supplemental life insurance coverage:

- **If you are faculty or staff**, you have the option of electing one to eight times your annual earnings, rounded to the next higher $1,000 (to a maximum of $3,000,000 in total basic and supplemental coverage, minus the $10,000 of basic life insurance); or **If you are a bargaining unit employee**, you may elect supplemental life insurance coverage equal to your base annual salary (to a maximum of $2,000,000 in total basic and supplemental coverage), rounded to the next lower $1,000. Certain amounts of supplemental life insurance may be subject to evidence of insurability.

Note: If you elected $40,000 in supplemental life coverage prior to January 1, 2019, you will continue to have this election until you elect to change your coverage. This coverage level will be open to only those who enrolled prior to the 2019 plan year.

**If you are a full-time visiting faculty member**, you are automatically provided with life insurance coverage equal to 150% of your annual base salary, rounded to the next lower $1,000, subject to a maximum of $1,000,000. JHU pays the full cost of this coverage. You may purchase supplemental insurance coverage equal to 100% of your annual base salary, rounded to the next lower $1,000, subject to a maximum of $1,000,000. You will pay the cost of this supplemental coverage, at a rate that varies by your age and benefit amount. Visiting faculty are not eligible for AD&D.

**Cost of Coverage**

You and JHU share in the cost of your life insurance coverage as shown in your Benefits Confirmation Statement. Life insurance costs are based on age.

Up to $50,000 of JHU-paid life insurance coverage may be provided as a tax-free benefit. However, the cost of any JHU-provided life insurance coverage greater than $50,000 will be reported on your W-2 form as part of your taxable income (this is called “imputed income”). For example, for $60,000 of life insurance, only the IRS imputed cost for $10,000 insurance ($60,000 minus $50,000) would be considered taxable income.

**Evidence of Insurability** If you are a newly-hired faculty or staff member, you can elect the highest level of life insurance coverage available to you; however, you must complete evidence of insurability if the coverage is greater than the lesser of 4 times annual earnings or $500,000 (to a maximum total coverage amount of $3,000,000). If you are a bargaining unit employee, you must complete evidence of insurability if the coverage is greater than $500,000, or if you are enrolling in supplemental coverage for the first time.
If you are a current employee and during annual enrollment you elect:

- To move up only one level of life insurance coverage, you will not have to complete evidence of insurability unless your request is greater than the lesser of four times your salary or $500,000 in total coverage.
- For faculty and staff to move up more than one level of life insurance coverage, you must complete evidence of insurability.
- For faculty and staff to elect supplemental coverage for the first time, you must complete evidence of insurability.
- For faculty and staff who make any election if you have been previously declined coverage, you must complete evidence of insurability.
- For bargaining unit employees to enroll in supplemental coverage for the first time, you must complete evidence of insurability.

If you elect, but do not qualify for a life insurance coverage level that requires evidence of insurability, your coverage amount will automatically be reduced to the highest option for which you are eligible that does not require evidence of insurability.

**Assignment of Your Benefits**

For purposes of estate tax planning, you may want to assign ownership of your basic life and/or supplemental life insurance benefits to another person or organization through irrevocable assignment. To obtain forms necessary to assign your Life Insurance coverage, contact the Benefits Service Center.

When you assign ownership, keep in mind that you give up the right to change or cancel your coverage. In addition, you cannot change your beneficiary or cancel your assignment yourself. If you assign ownership of your life insurance, you also give up the right to request advance payment of benefits if you become terminally ill.

You may wish to seek legal counsel before you make a decision to assign some or all of your benefits.

**How Dependent Life Insurance Works**

Dependent life insurance coverage is available for your eligible dependents. If you are enrolled in dependent life insurance, each of your eligible children is covered, no matter how many children you have.

- **If you are faculty or staff**, JHU offers two dependent life insurance coverage options for spouses, domestic partners and dependent children:
  - $4,000 of coverage for your spouse or domestic partner, plus $2,000 of coverage per child; or
  - $10,000 of coverage for your spouse or domestic partner, plus $5,000 of coverage per child.
- If you are faculty or staff, your first eligible newborn child is automatically enrolled in $2,000 of dependent coverage for the first 31 days after birth. To continue coverage on this child, you must elect dependent coverage within 31 days, otherwise the coverage will terminate after that period.

- If you are a bargaining unit employee, JHU pays for dependent life insurance coverage of $4,000 for your spouse or domestic partner, plus $2,000 of coverage per child.

You are automatically the beneficiary for dependent life and AD&D insurance on your dependents.

**Cost of Coverage**

If you elect dependent life insurance coverage for some or all of your eligible dependents, your premiums will be paid with after-tax dollars through payroll deductions.

**Other Life Insurance Plan Provisions**

See your plan summary included in the Appendix on page 148 for information about some additional plan provisions, including:

- Accelerated Benefits for Terminal Illness — If you or your covered dependent is diagnosed as terminally ill with a life expectancy of 12 months or less, you can request advance payment of your JHU life insurance benefits. You can receive up to 100% of your total coverage amount (basic plus supplemental). The minimum accelerated benefit you may request is $10,000. The maximum accelerated benefit is $1,000,000.

- Suicide Provision — Supplemental life insurance benefits (or a requested increase in your supplemental life insurance coverage) will not be paid if the deceased commits suicide while sane or insane, within two years of the coverage effective or increase date. Instead, the beneficiary will be paid an amount equal to all your contributions paid for supplemental life insurance coverage, without interest.

**How AD&D Insurance Coverage Works**

**Please note:** AD&D insurance coverage is available only to faculty and staff. Bargaining unit employees and visiting faculty are not eligible for coverage.

AD&D insurance protects you and/or your insured dependents, 24-hours a day, 365 days a year against covered accidents. Worldwide coverage includes (but is not restricted to) accidents on or off the job, occurring in the home, traveling by train, airplane (with certain exclusions), automobile or other public conveyance. AD&D insurance also includes other benefits, such as special education benefits, travel assistance and medical evacuation benefits.

Benefits are payable in addition to any other insurance coverage that may be in effect at the time of the accident. Please refer to the AD&D insurance policy for more detailed information. (This insurance does not replace business travel accident insurance, which is a JHU-paid benefit.)

JHU provides you with $10,000 of basic coverage at no cost. You may elect additional coverage amounts of one to eight times your annual earnings, rounded to the next higher $1,000 (to a maximum of $3,000,000 in total basic and supplemental coverage). You may also elect AD&D coverage for your dependents, as outlined below.
Amount and Cost of Coverage

JHU automatically provides you with $10,000 of basic AD&D insurance coverage at no cost. You have the opportunity to elect additional coverage of one to eight times your annual earnings, rounded to the next higher $1,000 (to a maximum of $3,000,000 in total basic and supplemental coverage) your salary for yourself and for your eligible dependents.

You pay the cost of any AD&D insurance you elect through pre-tax payroll deductions. If you elect AD&D insurance coverage for a domestic partner and/or their children, deductions are made on an after-tax basis, unless you certify that they are your dependents for tax purposes.

If you choose family coverage, in the event of a loss the coverage amount paid for you, your spouse or domestic partner, and for each eligible child, is based on the composition of your family at that time. This is expressed as a percentage of the elected amount, as shown in the following table:

<table>
<thead>
<tr>
<th>Family Composition</th>
<th>Your Coverage</th>
<th>Spouse’s or Domestic Partner’s Coverage</th>
<th>Coverage per Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>You, your spouse or domestic partner and children.</td>
<td>100% of your elected amount.</td>
<td>50% of your elected amount*.</td>
<td>20% of your elected amount.*</td>
</tr>
<tr>
<td>You and your spouse or domestic partner only.</td>
<td>100% of your elected amount.</td>
<td>60% of your elected amount.</td>
<td>N/A</td>
</tr>
<tr>
<td>You and your children only.</td>
<td>100% of your elected amount.</td>
<td>N/A</td>
<td>20% of your elected amount*.</td>
</tr>
</tbody>
</table>

*The maximum benefit per spouse/domestic partner is $250,000. The maximum benefit per child is $50,000.

How AD&D Benefits Are Paid

Benefits are paid for covered losses that occur within 365 days of, and as a direct result of, an accident or injury. The benefit amount depends on the coverage amount you choose and the extent of the loss.

An “accident” means an event that is unintended, unexpected and unforeseen during the time you are covered. It does not include any heart, coronary or circulatory malfunction.

If you have an accident that results in:

- **Death**: Your AD&D insurance pays 100% of the coverage amount you elected to your beneficiary. In the event of the death of a covered dependent, you receive benefits based on the percentages shown in the table above, describing family coverage.

- **Injury**: The benefit amount you receive depends on the extent of the loss. See the Certificate of coverage in the Appendix on page 148 for details.
**Additional AD&D Insurance Benefits**

See your plan summary included in the *Appendix* on page 148 for information about the following additional benefits offered under your supplemental accident insurance coverage (and in some cases, your basic AD&D coverage):

- Spouse Training Benefit
- Dependent Child Education Benefit
- Common Accident Benefit
- Coma Benefit
- Disappearance Benefit
- Exposure Benefit

**What’s Not Covered**

See your plan summary included in the *Appendix* on page 148 for a list of exclusions under the Basic and Additional AD&D insurance plans.

**How Business Travel Accident (BTA) Insurance Works**

BTA insurance is provided to all full-time and part-time professional and faculty employees, staff members, and bargaining unit employees. Coverage also extends to spouses, domestic partners or dependent children while accompanying you on a *business trip*.

A *business trip* means domestic or international travel that is approved by and at the direction of JHU for the purpose of furthering the business of JHU. This includes approved events you are attending such as business meetings, conferences, and seminars; whether locally or out of town.

BTA insurance provides different types of benefits for losses that may occur while you are traveling on a *business trip*. It includes benefits for accidental death, dismemberment, coma, and paralysis. Similar to AD&D insurance, the benefit amounts are scheduled as a percentage of the Principal Sum maximum, based on the type/severity of the accidental injury. This includes losses as a result of exposure or disappearance. Some other benefits and coverage features are also included, such as:

- **Out-of-Country Medical Expense benefit**: This helps pay medically necessary expenses that are a result directly of an accident or sickness. This benefit is payable as secondary and excess to amounts paid or payable by any other health care plan. This benefit is not major medical insurance. It is intended to fill gaps in coverage with your personal health insurance. It does not cover routine or elective treatment or supplies or maintenance treatment or supplies of a condition that occurred prior to the trip. Coverage applies while you are on a *business trip* outside of your home country.
**Emergency Medical Evacuation and Repatriation coverage:** If you were to suffer a medical emergency from an injury or sickness, this provides coverage for medically necessary expenses for medical transport, dispatch of a doctor or specialist, return of dependent child(ren), escort services, and transportation after stabilization. Coverage applies while you are on a business trip that is at least 100 miles or more away from your place of permanent residence. JHU’s emergency travel assistance provider (HX Global) must make all arrangements and obtain authorization for all expenses in advance.

**Security Evacuation coverage:** This provides coverage if you require transport to the safety to ensure your safety and well-being due to an Occurrence. Other related costs are also included. Occurrence means:

1) Being expelled or declared persona non-grata from a host country,
2) Political or military events involving a host country resulting in an advisory stating you should leave the Host Country,
3) Natural disaster,
4) Being the victim of a physical attack or threat of physical attack from a third party.

Coverage applies while you are on a business trip outside of your home country. JHU’s emergency travel assistance provider (HX Global) must make all arrangements and obtain authorization for all expenses in advance.

**Amounts and Cost of Coverage**

JHU provides you with coverage at no cost.

- For accidental death, dismemberment, coma, & paralysis, the Principal Sum maximums are:
  - Full-time and part-time professional and faculty employees, staff members, and bargaining unit employees: three times Annual Salary to a maximum of $500,000
  - Spouse: $50,000
  - Dependent Child(ren): $25,000
- For Out-Of-Country Medical Expense benefits the maximum is: $150,000 per sickness or injury.
- For Emergency Medical Evacuation and Repatriation coverage, the maximum is: 100% of covered expenses.
- For Security Evacuation coverage, the maximum is: $100,000.


**Additional Accident Benefits**

- Cosmetic Disfigurement from Burns
- Home Alteration and Vehicle Modification
- Rehabilitation
- Seatbelt and Airbag
- Dependent Child Care Expenses
- Special Counseling
- Spouse Retraining

**Benefit Limitations**

For accidental death, dismemberment, coma, & paralysis benefits (including additional accident benefits), BTA insurance has an aggregate maximum limit of $5,000,000 for all losses in a single accident. If the total claims from a single accident exceed $5,000,000, benefits payable to each person with a will be reduced proportionately based on the total amount of insurance that would have been payable if there was no benefit limitation.

Security Evacuation coverage is subject to an aggregate limit per Occurrence of $500,000. Coverage is also limited under certain circumstances (e.g., if the loss is associated with scuba diving).

**What’s Not Covered**

BTA insurance coverage does not apply during any period of time:

- While working at your regular place of employment;
- During the course of everyday travel to and from work (commutation); or
- During an authorized leave-of-absence or vacation.

The BTA insurance has several terms, conditions, limitations, and exclusions. Contact the plan administrator for additional details.
Dependent Care FSA at a Glance

<table>
<thead>
<tr>
<th>Dependent Care Flexible Spending Account</th>
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<tbody>
<tr>
<td><strong>Why Participate</strong></td>
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<tr>
<td><strong>What’s Reimbursed?</strong></td>
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<tr>
<td><strong>How Much You Can Contribute</strong></td>
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<tr>
<td><strong>“Use or Lose It” rule</strong></td>
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</tbody>
</table>
Your Contributions

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

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

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

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

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

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**If You Receive Employer-Provided Day Care**

The combination of benefits from the Child Care Voucher, the DCFSA, and Backup Care through Care@Work (or any other employer-provided day care benefit you receive) cannot exceed $5,000 per year. You are responsible for monitoring your usage of these funds at WEX. If you exceed $5,000 in any calendar year, the excess funds are reported as taxable income.
Whose Expenses Are Eligible?
The Dependent Care FSA can be used only to reimburse expenses for the care of eligible dependents. Under IRS rules and regulations, “eligible dependents” for the dependent care FSA include:

- A child under age 13 who is your “qualifying child”;  
- A disabled spouse who lives with you for more than one half the year; and  
- A “qualifying relative“ if that person receives more than one-half of their support from you, resides in your home, is physically or mentally unable to care for him or herself, and who is not the qualifying child of the employee or any other individual.

Please note: Under federal tax law, the Dependent Care FSA may not be used for expenses of domestic partners or their children, unless they qualify as your “eligible dependent”.

What Expenses Are Eligible?
Dependent care FSA covers only eligible dependent care expenses, not health care expenses. Eligible expenses for the care of eligible dependents generally include the following:

- Care provider fees in your home;  
- Care provider fees in another person's home;  
- Care provided at a licensed nursery school, day camp (not overnight camp) or qualified day care center in compliance with applicable state and local requirements; or  
- Before or after school programs.

Expenses must be incurred in order to allow you — or if you’re married, you and your spouse — to work or if your spouse is disabled and unable to care for him/herself or is a full-time student for at least five months of the year. To be eligible, expenses must have been incurred during the plan year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill.

If the care is provided in your home or the home of another person, the care provider must not be claimed as a dependent on your tax return and must be age 19 or older (determined as of the close of the taxable year). An adult dependent must spend at least 8 hours a day in your home in order for expenses for caring for that person to be eligible. Services must be for the physical care of the child, not for education, meals, etc., unless incidental to the cost of care.

For a list of eligible expenses, find a complete list online at [www.irs.gov](http://www.irs.gov).
What Expenses Are Not Eligible?
For a list of ineligible expenses, visit www.irs.gov.

Use It or Lose It

It is important to plan your contributions to the dependent care FSA carefully. The IRS requires that you must use the full amount of money in your dependent care flexible spending account for expenses incurred during the plan year, or forfeit what remains. You must incur eligible expenses within the plan’s timeframe – no later than March 15 of the following plan year, or two and a half months after the end of the plan year – in order for them to be eligible for reimbursement. Your request for reimbursement must be filed by April 30 of the following plan year. Any funds remaining in your account after that date will be forfeited.

If your employment terminates during the plan year, you may continue to submit dependent care expenses incurred while you were an active employee. Claims must be filed within 120 days of your last day of active employment.

You may not use money in your dependent care FSA to pay health care expenses and vice versa. You may not switch money between the two accounts.

Filing Claims for Benefits

The Dependent Care FSA is administered by WEX. After you enroll, you may access your account online or by phone. Your account statement details your last month’s account activity and may also include items that require your immediate attention. You may complete a Recurring Dependent Care Request Form, which allows you to schedule regular reimbursements to yourself from your dependent care FSA.

Here’s how to file a claim for reimbursement from your Dependent Care FSA:

▪ Use your WEX debit card (if provider accepts debit cards).
▪ Complete and submit the Recurring Dependent Care Request Form.
▪ Pay your care provider and if possible, obtain a receipt.
  ❖ Attach a dated receipt to the form, and send both to the address shown on the form. Your receipt can be a bill, an invoice or a receipt only.

You can have your Dependent Care FSA reimbursement checks mailed to you or you can elect direct deposit of these amounts into your checking or savings account. To use the direct deposit feature you will need to complete the direct deposit setup from your online account.

You can be reimbursed only up to the amount in your account at the time you file a claim. If your claim exceeds the balance in your account, the outstanding amount will be carried over and paid automatically as new contributions are added to your account. However, if you terminate participation during the year, you will not be reimbursed for claims incurred after your termination of participation.
Coordination with Voucher and Backup Care Programs

As discussed in further detail below, the University offers programs to help offset the cost of child care for eligible employees: child care vouchers and backup emergency care. The combined maximum amount of Dependent Care FSA funds, child care voucher, and backup emergency care cannot exceed $5,000. If the combined totals exceed applicable limits, the excess amounts will be treated as taxable income to you.

Special Rules Affecting Dependent Care FSA

The IRS requires that the maximum amount you can take as a child care tax credit for dependent care expenses be deducted — dollar for dollar — by any reimbursements you receive from your Dependent Care FSA. Some employees will receive more tax advantages by taking the dependent care tax credit, while others will do better by contributing to the dependent care flexible spending account. Please consult your tax advisor or carefully review your situation before making a choice.

If you and your spouse are divorced and you have custody of your child, you may be able to be reimbursed from the Dependent Care FSA even if you do not claim the dependent on your federal income tax return. See IRS Publication #503 for more information. A copy of that publication can be obtained at www.irs.gov.
Other Benefits

Your JHU benefits program includes a number of other benefits designed to promote wellness and help you manage the demands of your work and personal life. The benefits described in this section of your Handbook include:

- Employee Assistance Program
- Worklife programs
- Legal Insurance

Commuter Benefits

Auto and Homeowner’s Insurance

Travel Assistance and Identity Theft Insurance

Employee Assistance Program

The Employee Assistance Program (EAP) is directed by JHU’s Office of Benefits and WorkLife and is a collaboration between the EAP Onsite Clinical Team and Corporate Counseling Associates, Inc. ("CCA") under a contract with JHU. EAP clinical services are delivered by EAP onsite clinicians (employed by JHU), telephonic clinicians (employed by CCA), and affiliated network providers (third party providers contracted with CCA).

EAP services include:

- Free and confidential professional assessment and support for the challenges of daily living;
- Assessment of emotional well-being;
- Short-term, solution-focused counseling;
- Referrals to behavioral health benefits and other resources as needed to support emotional well-being;
- Telephonic, televideo, and in-person counseling;
- On-site crisis response and support for critical incidents;
- Consultation to managers, leaders, Occupational Health Services, Safe at Hopkins, the Professional Assistance Committee and Nursing Professional Assistance Committee, Human Resources, and other committees and departments when there’s a concern about an employee’s conduct or well-being;
- Expertise in counseling and supporting employees with substance use or behavioral problems.
Eligibility

EAP services are available to all employees, spouses, domestic partners, household members and dependents (including adult children up to age 26). Counseling services involving mental health and substance use disorder problems can be continued under COBRA and are automatically extended to former employees (and their spouses, domestic partners, and household members and benefits-eligible dependents of employees) for 18 months under COBRA continuation coverage rights.

Scheduling an Appointment with the EAP Onsite Clinical Team

To schedule an appointment with a EAP Onsite Clinician, please call 443-997-7000 or request an appointment via the JHU HR website: https://hr.jhu.edu/benefits-worklife/support-programs/onsite-clinical-care/make-an-appointment/.

All those attending appointments with a member of the EAP Onsite Clinical Team must sign a Consent for Services Agreement form at their first appointment.

Worklife Programs

Whether you’re having a baby, raising a child, or caring for an aging relative, we have resources for you, from lactation support, to adoption assistance, to help finding—and paying for—child care and eldercare. These programs and benefits are listed below. Please note that some of these programs and benefits may be treated as taxable income to you – please contact the Benefits Service Center for more information.

- Baby Shower — Get ready for that new addition to your family. Join us for the next Johns Hopkins Baby Shower, a semi-annual event that provides new and expectant parents with information about leave for new parents, lactation support, child care options, and other available resources.

- Finding Child Care — Looking for quality child care in Maryland? Find options through our LOCATE: Child Care partnership and receive individual counseling to assess your child care needs and then be matched with available services. You’ll receive referrals to registered family child care providers and licensed group programs, as well as follow-up assistance until placement is found. LOCATE also provides materials on specialized child care options and services, federal income tax credits for families, and state financial assistance programs. Our Finding Child Care page also offers links to child care provider networks and services, some of which offer discounted rates to JHU employees.

- Backup Care — We’ve partnered with Care.com to provide 10 days of backup care per year at a reduced rate that’s based on your salary. Care.com prescreens qualified caregivers to help you find in-home backup emergency care, or in-center backup care for children. You also receive a free premium Care.com membership, which allows you to perform self-directed searches for a variety of caregiving needs. As noted above, generally, dependent backup care, combined with the voucher and Dependent Care FSA, cannot exceed $5,000..

- Paying for Child Care — Your JHU benefits include two programs that can help offset the cost of child care for eligible employees: child care vouchers and dependent care flexible spending accounts. As noted above, if the combined total of your Dependent Care FSA, any
Other Benefits

backup care, and child care vouchers exceeds applicable limits, then the excess amounts will be treated as taxable income to you. In addition, JHU’s LifeMart employee discount program can also help cut your costs.

- JHU Child Care Center Partners — JHU partners with three high-quality Baltimore-area child care centers that give admission and wait list priority to JHU employees. We also have relationships with other quality centers that offer wait list priority to our employees.

- Scholarships to JHU Child Care Centers — JHU scholarships are available for the three centers that are Johns Hopkins partners: Homewood Early Learning Center, Bright Horizons, and the Weinberg Early Childhood Center. These scholarships can be used in addition to vouchers. They are available to full-time employees of the university, post-doc students, full-time doctoral students, residents, and house staff.

- Choosing Quality Care — As a parent, you’re responsible for assessing and monitoring the quality of the child care you choose. It’s important—and sometimes stressful—but we’ve got resources that can help, including safety information offered through our partnership with Care.com.

- Lactation Support — Locate and register to use lactation rooms equipped with hospital-grade pumps and other comforts, get tips on successful milk expression after your return to work, and find manager resources, plus information on laws and JHU policies.

- Family Leave for New Parents — Parents can take paid time off using JHU’s birth recovery leave and parental leave after the birth or adoption of a child younger than 12.

- Adoption Assistance — In addition to paid parental leave for parents adopting a child under the age of 12, we offer an Adoption Assistance Plan that can provide up to $15,000 toward eligible adoption costs.

- Aging Adult Services — We have a host of programs that can ease the challenges—emotional, financial, and practical—of caring for an aging adult.

Learn more about these programs online at https://hr.jhu.edu/benefits-worklife/family-programs/.

Legal Insurance

The Hyatt Legal plan provides participants with unlimited access to nearly 12,000 attorneys nationwide at discounted rates. You can get in touch with an attorney either by phone or in person. Please note that this Handbook is not the SPD for the Legal Insurance benefit. Please refer to the Hyatt Legal SPD as listed on the Appendix on page 148.

Eligibility

As a full-time faculty, staff and bargaining unit member, you can participate in a voluntary benefits program to purchase discounted legal insurance. You can enroll at hire or during annual enrollment.
About the Program

The Hyatt Legal Plan gives you access to a nationwide network of more than 12,000 attorneys, to help you and your dependents with vital legal matters such as:

▪ Estate planning: preparation of wills, codicils, testamentary trusts, living wills, living trusts, deeds, and powers of attorney
▪ Financial: creditor issues, debt collection defense, identity theft defense, tax audits, and the purchase, sale, and refinancing of a home

You can receive a consultation over the phone or in person.

How to Enroll

Additional plan details can be found on the Johns Hopkins University Voluntary Benefits website at www.jhuvoluntarybenefits.com and in the Hyatt Legal SPD. Enrollment is completed online through myChoices Health & Life.

If you wish to speak with a service representative, contact Mercer, the administrators of our voluntary benefits program at 866-795-9362.

Commuter Benefits

Our commuter assistance program allows you to pay for public transportation or parking with pre-tax dollars, saving you money on your commute.

Eligibility

You are eligible for the JHU Commuting-to-Work program if you are a full-time or part-time faculty or staff member who is paid semi-monthly. Visiting faculty and Bargaining Unit members are not eligible for this benefit.

About the Program

This program allows you to have pre-tax deductions taken from your pay to cover eligible expenses associated with your commute to work. You may elect a transit account (public transportation), parking account (non-JHU parking lots), or both. Through WEX, our commuter benefit provider, you can make a one-time election to cover the same expenses each month. Or, if your commuting needs change regularly, you may elect to cover different expenses every month. Payroll deductions will be loaded onto a WEX debit card to use for making your purchases for mass transit or non-JHU parking.

The cost of the transit or non-JHU parking will be deducted from your paycheck over two pay periods.
**Pre-Tax Commuting-to-Work Limits**

The JHU Commuting-to-Work Program treats qualified parking and mass transit expenses on a pre-tax basis which means the amounts are excluded from your taxable income up to the amount allowed by the IRS. For tax year 2022, the monthly pre-tax spending limit for non-JHU parking was $280 per month. The limit for mass transit was also $280 per month.

WEX, our commuter benefits provider, offers a debit card to purchase transportation and non-JHU parking passes or the ability to reimburse yourself monthly for non-JHU parking fees. For more information or to enroll in the commuter program, contact WEX at 866-451-3399 or visit www.wexinc.com.

**Mass Transit**

WEX covers some commuting expenses, such as a WMATA SmarTrip card, directly—your money is loaded onto your SmarTrip card for you. A WEX debit card is also available. The debit card is a reusable stored value card which can be used to purchase MTA passes and tickets or to add monies to the Baltimore City CharmCard. For other expenses, you will be required to pay out-of-pocket and request reimbursement from WEX. After you incur the eligible expenses, submit your claim directly to WEX for reimbursement via your online account or the mobile app.

**Non-JHU Parking**

If you park at a non-JHU garage or facility, the WEX debit card can be used to pay the facility directly. If you park at a JHU facility and have your parking fee deducted from your paycheck, you automatically receive the pre-tax benefit.

**How to Enroll**

**Online**

- Enrollment is completed online through myChoices Health & Life.
- After you enroll, WEX will send you an enrollment confirmation email and you will receive a WEX debit card in the mail.
- The cost will automatically be deducted from your paycheck and applied to the WEX debit card.

**Phone**

Call WEX at 866-451-3399, Monday through Friday, 7 a.m. to 8 p.m.
Auto and Homeowner’s Insurance

Save money on insurance through the Choice Auto and Homeowner’s Insurance Program, which offers you a competitive quote from a selection of top-rated auto and homeowner’s insurers and provides special discounts for JHU employees. The program is administered for JHU by Mercer Voluntary Benefits.

Eligibility

As a full-time faculty, staff and bargaining unit member, you can participate in a voluntary program to purchase discounted auto and homeowner’s insurance.

About the Program

The Choice Auto and Homeowner’s Insurance Program offers you a competitive quote from a selection of top-rated auto and homeowner’s insurers. Compare the coverage side by side and determine if there is an option that meets your needs. You can insure more than your vehicle and home — you may also be eligible to cover a rental property, boat, or motor home.

Additional discounts may be available, such as:

▪ Special group discount of 10% or more for JHU faculty and staff
▪ Long term JHU service discount based on number of years employed
▪ Convenient payroll deduction discount when premium is paid through payroll
▪ Multi-policy, multi-car, safe driver and anti-theft device discounts

How to Enroll

▪ Follow the brief instructions to access and complete your enrollment.
▪ Call 866-795-9362, Monday to Friday, 9 a.m. to 6 p.m., with questions.
Travel Assistance and Identity Theft Insurance

Offered through Securian, the travel assistance benefit provides pre-trip planning and support, emergency medical assistance, and security evacuation services any time you are 50 miles or more from home.

If you are enrolled in the university’s basic life insurance plan through Securian, you have a Travel Assistance benefit available that offers you and your family member’s assistance when you are 50 miles or more away from home. It provides three primary types of assistance when you travel for business or pleasure:

▪ Pre-Trip Information (e.g., Visa, Passport, immunization requirements, foreign exchange rates, etc.)
▪ Emergency Medical Assistance (e.g., pre-hospital and rental vehicle assistance, transport to nearest appropriate medical facility, mortal remains repatriation, etc.)
▪ Security Evacuation Services (e.g., transfer to nearest safe area, ID theft support, assistance replacing lost or stolen luggage, etc.).

Learn more or access services at www.LifeBenefits.com/travel or by calling 1-855-516-5433 (U.S./Canada) or 1-415-484-4677 (all other locations).
Administrative Information

This Handbook is an overview of your benefits available through the JHU Welfare Plan (Plan 501) for active employees, and the JHU Retiree Health Plan (Plan 514) for certain retirees. This Handbook serves as a summary plan description for both plans within the meaning of ERISA purposes. These plans allow you to choose between several benefits or “component plans.”

The JHU Welfare Plan is a form of employee welfare benefit plan called a “cafeteria plan” because it allows you to choose benefits. You are given the opportunity to direct the employer to reduce your salary by a specified amount to purchase benefits under the plan. For certain benefits, because your salary is reduced before federal and state taxes are imposed, you pay less in taxes if you participate in the plan. (Please note that in some instances, you may be required to make after-tax contributions.)

The JHU Retiree Health Plan allows eligible retirees to select between medical and dental benefits. Participants in the Retiree Health Plan are only eligible to participate in the medical and dental component plans.

The official plan documents and contracts contain full details of the legal provisions of each welfare and component plan. In case of a conflict between the official plan documents, the summaries provided here in the Summary Plan Description, any other written materials, or any oral statements made to you concerning your benefits, the official plan documents will govern.

The Plans will provide benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Newborns’ and Mothers’ Health Protection Act (NMHPA), the Women’s Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and all relevant provisions of the Patient Protection and Affordable Care Act (PPACA).

You may review or obtain copies of the official plan documents. To receive copies, contact the Benefits Service Center via email at benefits@jhu.edu, or call 410-516-2000. Office hours are Monday through Friday, 8:30 am — 5:00 pm.

The Johns Hopkins University
Benefits Service Center (Eastern)
1101 East 33rd Street, Suite D200
Baltimore, MD 21218
Fax: 1-443-997-5820
Plan Amendment or Termination

JHU reserves the right to amend, modify or terminate, at any time and for any reason, any or all of the welfare or component plans and programs described in these materials, including with respect to any retirees that are already enjoying retiree benefits. JHU also has the right to institute or change the level of employee contributions for any of these benefits. You will be notified of any change.

ERISA Information

Participants in particular JHU benefit plans and their beneficiaries receiving benefits are entitled to certain rights and protections under the Employee Retirement Income and Security Act of 1974, as amended (ERISA).

The following JHU benefits are provided under ERISA plans:

- Medical and Prescription drug
- Dental
- Vision
- Retiree Health Plan
- Critical Illness Insurance
- Health care flexible spending account (general and limited purpose)
- Life Insurance (basic, supplemental and dependent)
- Accidental death and dismemberment insurance
- Business travel accident insurance
- Long-term disability
- Short-term disability
- Employee Assistance Program
- Onsite Clinics
- Legal Insurance

The following JHU plans/programs are not covered by ERISA:

- Dependent care flexible spending account
- Dependent care voucher program
- Back-up child care program
- Health Savings Account (HSA)
- Commuter benefits
- Auto and Homeowner’s Insurance
- Identity Theft Insurance
The remainder of this section provides important administrative information about JHU’s ERISA plans and summarizes your rights under ERISA as a plan participant. The administrative facts and other information provided in this section, together with all of the other information provided in this document describing ERISA plan benefits, constitute the Summary Plan Descriptions for JHU’s ERISA plans unless otherwise noted herein.

**Basic Plan Facts**

**Plan Name**

**The Johns Hopkins University Welfare Plan**

*Plan Number*

501

*Plan Year*

January 1 through December 31

The Plan is a welfare benefit plan providing the component plans listed below, and a “cafeteria plan” in which participants can use either pre-tax or after-tax dollars to choose between different welfare component plans.

**The Johns Hopkins University Retiree Health Plan**

*Plan Number*

514

*Plan Year*

July 1 through June 30

The Plan is a retiree welfare plan offering medical and dental benefits.

**Plan Sponsor**

The Johns Hopkins University
Johns Hopkins at Eastern
1101 E. 33rd Street, Suite D200
Baltimore, Maryland 21218

*Employer Identification Number*

52-0595110
Plan Administrator

The Johns Hopkins University. Plan Administrator correspondence should be mailed to:

The Johns Hopkins University
Office of Benefits Services
Johns Hopkins at Eastern
1101 E. 33rd Street, Suite C020
Baltimore, Maryland 21218

Telephone number: **410-516-2000**
E-mail: benefits@jhu.edu

Plan Agent for:

Service of Legal Process

The Vice President of Human Resources, whose address is the same as the University’s address. Process may also be served on the Plan Administrator.

Funding Medium

Plan benefits are provided through a mix of insurance contracts or from the Employer’s general assets.

Source of Contributions

The contributions for the plans are a mixture of employer and employee contributions.

Component Plans Under The Johns Hopkins University Welfare Plan and The Johns Hopkins University Retiree Health Plan

JHU BlueCross BlueShield Plan (CareFirst BlueCross BlueShield Medical and CareFirst BlueCross BlueShield Plan III)

Type of Plan

An employee welfare plan providing medical, dental, and prescription drug benefits.

Type of Administration

The Plan Administrator manages the plan on a day-to-day basis and resolves questions about plan details and eligibility for benefits; the administration of the benefit plan is provided through a Claims Administrator.
Claims Administrator or Plan Insurer
- The plan is not insured.
- The Claims Administrator is:
  CareFirst BlueCross BlueShield (CareFirst).
  10455 Mill Run Circle
  Owings Mills, MD 21117
  410-581-3000

Funding
Claims are paid from the general assets of JHU.

Appeals Process
Claims appeals are handled by CareFirst BlueCross BlueShield; appeals related to eligibility, enrollment, and qualifying event changes are handled by the JHU Benefits Appeals Committee.

EHP Classic Plan
Type of Plan
An employee welfare plan providing medical and prescription drug benefits.

Type of Administration
The Plan Administrator manages the plan on a day-to-day basis and resolves questions about plan details and eligibility for benefits.

Claims Administrator or Plan Insurer
- The plan is not insured.
- The Claims Administrator is:
  JHU Employer Health Programs
  7231 Parkway Drive, Suite 100
  Hanover, MD 21076
  410-424-4450
  800-261-2393

Funding
Claims are paid from the general assets of JHU.

Appeals Process
Claims appeals are handled by EHP; appeals related to eligibility, enrollment, and qualifying event changes are handled by the JHU Benefits Appeals Committee.
JHU Health Maintenance Plan (BlueChoice HMO*)

Type of Plan
An employee welfare plan providing medical and prescription drug benefits.

Type of Administration
The plan is administered by CareFirst BlueChoice Inc. through an insurance contract.

Claims Administrator or Plan Insurer
- The plan is not insured.
- The Claims Administrator is:
  CareFirst BlueChoice Inc.
  Central Appeals and Analysis Unit
  P.O. Box 17636
  Baltimore, MD 21297-1636
  410-581-3000

Funding
Benefits are paid from the general assets of JHU.

Appeals Process
Claims appeals are handled by CareFirst BlueChoice; appeals related to eligibility, enrollment, and qualifying event changes are handled by the JHU Benefits Appeals Committee.

* The JHU Health Maintenance Plan (CareFirst BlueChoice) is available only to certain participants. Please contact the Benefits Service Center for more information.

JHU Health Maintenance Plan (Kaiser Permanente HMO)

Type of Plan
An employee welfare plan providing medical, and prescription drug benefits.

Type of Administration
The plan is administered by Kaiser Permanente through an insurance contract.

Claims Administrator or Plan Insurer
- The plan is insured.
- The Insurer is:
  Kaiser Permanente
  ATTN: Member Services Appeals Unit
  2101 East Jefferson Street
  Rockville, MD 20852
  800-777-7902
Funding
Benefits are insured by Kaiser Permanente.

Appeals Process
Claims appeals are handled by Kaiser Permanente; appeals related to eligibility, enrollment, and qualifying event changes are handled by the JHU Benefits Appeals Committee.

Component Benefit Plans Under The Johns Hopkins University Welfare Plan

JHU Group Dental Plans

Type of Plan
An employee welfare plan providing dental benefits.

Type of Administration
The administration of the benefit plan is provided through a Claims Administrator identified below.

Claims Administrator or Plan Insurer
- The Delta Dental of PA plans are not insured.
- Delta Dental of PA is the Claims Administrators for the benefit plans. The address and telephone numbers are:
  Delta Dental of PA, Inc.
  One Delta Drive
  Mechanicsburg, PA 17055-6999
  800-422-4234

Funding
Benefits are paid from the general assets of JHU on behalf of the plan in accordance with a contract with Delta Dental of PA.

Appeals Process
Claims appeals are handled by Delta Dental; appeals related to eligibility, enrollment and qualifying event changes are handled by JHU Benefits Appeals Committee.

JHU Group Vision Plan

Type of Plan
An employee welfare plan providing vision benefits.

Type of Administration
The plan is administered by EyeMed (Combined Insurance Company of America) through an insurance contract.
Claims Administrator or Plan Insurer
Combined Insurance Company of America
4000 Luxottica Place
Mason, OH 45040
888-581-3648

Funding
Benefits are insured by EyeMed (Combined Insurance Company of America).

Appeals Process
Claims appeals are handled by EyeMed (Combined Insurance Company of America); appeals related to eligibility, enrollment and qualifying event changes are handled by JHU Benefits Appeals Committee.

JHU Group Life Insurance Plan
Type of Plan
An employee welfare plan providing life insurance benefits.

Type of Administration
The plan is administered by Securian Financial Group through an insurance contract.

Claims Administrator or Plan Insurer
Securian Financial Group
400 Robert Street North
St. Paul, MN 55101
888-658-0193

Funding
Benefits are insured by Securian Financial Group.

Appeals Process
Claims appeals are handled by Securian Financial Group; appeals related to eligibility, enrollment and qualifying event changes are handled by JHU Benefits Appeals Committee.

JHU Group AD&D Plan
Type of Plan
An employee welfare plan providing AD&D benefits.

Type of Administration
The plan is administered by Securian Financial Group through an insurance contract.
Claims Administrator or Plan Insurer
Securian Financial Group
400 Robert Street North
St. Paul, MN 55101
888-658-0193

Funding
Benefits are insured by Securian Financial Group.

Appeals Process
Claims appeals are handled by Securian Financial Group; appeals related to eligibility, enrollment and qualifying event changes are handled by JHU Benefits Appeals Committee.

JHU Group Long-Term Disability Plan

Type of Plan
An employee welfare plan providing long-term disability insurance benefits.

Type of Administration
The plan is administered by the Plan Administrator through an insurance contract purchased from Lincoln Financial Group. Certain ministerial functions are performed on behalf of the plan by Lincoln Financial Group; these functions include, but are not limited to, administration and payment of claims, determination of your eligibility under the plan, premium billing and policy and certificate issuance.

Claims Administrator or Plan Insurer
Lincoln Financial Group
100 Liberty Way, Suite 100
Dover, NH 03280-4695
888-246-4483

Funding
Benefits are funded through an insurance contract issued by Lincoln Financial Group.

Appeals Process
Claims and appeals are handled by Lincoln Financial Group; appeals related to eligibility, enrollment and qualifying event changes are handled by JHU Benefits Appeals Committee.
**JHU Group Short-Term Disability Plan**

*Type of Plan*
An employee welfare plan providing short-term disability insurance benefits.

*Type of Administration*
The plan is administered by the Plan Administrator through an insurance contract purchased from Lincoln Financial Group. Certain ministerial functions are performed on behalf of the plan by Lincoln Financial Group; these functions include but are not limited to, administration and payment of claims, determination of your eligibility under the plan, premium billing and policy and certificate issuance.

*Claims Administrator or Plan Insurer*
Lincoln Financial Group  
100 Liberty Way, Suite 100  
Dover, NH 03280-4695  
888-246-4483

*Funding*
Benefits are funded through an insurance contract issued by Lincoln Financial Group.

*Appeals Process*
Claims and appeals are handled by Lincoln Financial Group; appeals related to eligibility, enrollment and qualifying event changes are handled by JHU Benefits Appeals Committee.

**JHU Business Travel Accident Insurance Plan**

*Type of Plan*
An employee welfare plan travel accident insurance benefits.

*Type of Administration*
The plan is administered by Lincoln Financial Group through an insurance contract.

*Claims Administrator or Plan Insurer*
Lincoln Financial Group  
100 Liberty Way, Suite 100  
Dover, NH 03280-4695  
888-246-4483

*Funding*
Benefits are insured by Lincoln Financial Group.

*Appeals Process*
Claims and appeals are handled by Lincoln Financial Group.
**Health Care (and Limited Purpose) Flexible Spending Account**

*Type of Plan*

An employee welfare plan providing health benefits.

*Type of Administration*

The plan is administered by JHU.

*Claims Administrator or Plan Insurer*

WEX is the Claims Administrator.

WEX
PO Box 2926
Fargo, ND 58108-2926
866-451-3399

*Funding*

JHU does not contribute to the Health Care FSAs. All contributions are made by employees and are held as general assets of JHU. JHU pays the cost to administer the Health Care and Limited Purpose FSA only.

*Appeals Process*

Claims and appeals are handled by WEX; appeals related to eligibility, enrollment and qualifying event changes are handled by JHU Benefits Appeals Committee.

**Employee Assistance Program**

*Type of Plan*

An employee welfare plan providing personal and financial assistance.

*Type of Administration*

The plan is administered by JHU.

*Claims Administrator or Plan Insurer*

The plan is not insured.

*Funding*

Benefits are paid from the general assets of JHU.

*Appeals Process*

Claims and appeals are handled by CCA with the exception of any claims or appeals relating to services provided by JHU-employed EAP clinicians. Such claims and appeals of ERISA-covered benefits offered by JHU-employed EAP clinicians, as well as appeals related to eligibility, enrollment and qualifying event changes, are handled by JHU Benefits Appeals Committee.
JHU Onsite Clinics

Type of Plan
An employee welfare plan providing medical, and prescription drug benefits.

Type of Administration
The plan is administered by Johns Hopkins University.

Claims Administrator or Plan Insurer
The plan is self-insured.

Funding
Benefits are paid from the general assets of JHU on behalf of the plan.

Appeals Process
Claims appeals are handled by the JHU Benefits Appeals Committee.

ERISA Rights
As a plan participant, you are entitled to certain rights and protections under ERISA, as outlined in this section.

Right to Receive Information About Plan and Benefits
You are entitled to examine, without charge, at the Plan Administrator’s office during normal business hours and at other specified locations, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You are also entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. You may be charged a reasonable charge for copying and mailing the documents.

You are also entitled to receive a summary annual report of the plans’ annual financial reports.

Continue Group Health Plan Coverage
You are entitled to continue health care coverage for yourself, your spouse, your domestic partner or dependents if there is a loss of coverage under the plan as a result of a COBRA qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people or entities that
operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Outreach, Education and Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**Allocation of Fiduciary Responsibility**

The Plan Administrator for each ERISA plan has full power and discretionary authority to administer the applicable benefit plan. This includes, but is not limited to, discretionary authority to determine all questions relating to eligibility to participate in, be covered by, and receive a benefit under the plans. With respect to certain of its benefit plans, the Plan Administrator has delegated its fiduciary authority for claim determinations to each plan’s named Claims Administrator or Plan Insurer. In exercising its fiduciary responsibility, the Claims Administrator or Plan Insurer has discretionary authority to make factual determinations to determine with final authority whether or, and to what extent, employees and their dependents are entitled to benefits, and to construe plan terms.
Any exercise of discretionary authority that has been granted to a plan fiduciary is final and binding on participants, beneficiaries, and any other interested party.

**Acts of Third Parties**

When you or your covered dependent are injured, or become ill, because of the actions, or inactions of a third party, the Plan may cover your eligible health care (medical, dental and vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan’s procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else’s fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made on your behalf by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid to (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;

- May appoint you as constructive trustee for any and all monies paid to (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and

- May bring an action on its own behalf or on the covered person’s behalf, or intervene in any pending lawsuit, against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section — through a judgment, settlement or otherwise — when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses. Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney’s fees and costs) you incur in obtaining the funds.
The Plan’s sources of payment through subrogation or recovery include (but are not limited to) the following:

▪ Money from a third party that you, your guardian or other representatives receive or are entitled to receive;

▪ Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;

▪ Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and

▪ Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers’ compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

▪ Provide proof, if requested by the Claims Administrator and in the form requested by the Claims Administrator, that you have not and will not discharge or release a claim against a third party without the written consent of the Claims Administrator.

▪ Execute a written agreement assigning your rights against a third party to the Plan and/or authorizing the Plan to sue, compromise or settle a cause of action against a third party, if requested by the Claims Administrator.

▪ Cooperate with the Plan’s efforts to ensure a successful subrogation or recovery claim, including instituting a formal proceeding against a third party and/or setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan’s subrogation or recovery rights outlined in this Summary.

▪ Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.

▪ Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan. If the Plan must institute proceedings against you for not honoring the Plan’s recovery rights under this section, you will be responsible for the costs of collection, including reasonable attorney’s fees.

If the "Acts of Third Parties" provisions on page 128 conflict with provisions in a Benefit Booklet governing insured benefits, the Benefit Booklet will govern. If the Benefit Booklet for any self-insured benefit contains subrogation, reimbursement or recovery provisions, those provisions and the "Acts of Third Party" provisions in this SPD will both apply, so that the Plan has the maximum subrogation, reimbursement, and recovery rights.
Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

Non-assignment of Benefits

Plan participants cannot assign, sell, transfer, pledge, borrow against, or otherwise promise any benefit payable under the plan or the right to assert legal rights, including an administrative claim or lawsuit against any of the following: the plan, the Plan Administrator, a claims administrator, any plan fiduciary, JHU, or its officers or employees. For example, participants may not assign their right to receive benefits and legal rights relating to the plan to any health care provider—such assignment is not permitted and is void. The Plan Administrator or Claims Administrator may make payment directly to the participant or, at its discretion, make payment directly to a doctor, hospital, or other provider. When payment is made directly to a doctor, hospital or other provider, such payments are solely at the discretion of the Plan Administrator or claims administrator—such payments do not create any enforceable assignment of benefits or the right to assert any legal rights or to bring any administrative claim or lawsuit by any doctor, hospital, or other provider of care against the Plan (or the Plan Administrator, Claims Administrator, any Plan fiduciary, JHU, or its officers or employees).

The Plan will, when required by law or applicable guidance, recognize an assignment of benefits to a state Medicaid program.

Misstatements and Misrepresentations

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

If you or your dependent(s) receive benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation, you may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. If you make any intentional misrepresentation or use fraudulent means concerning eligibility for coverage, changing your existing coverage, or benefits under the Plan, your coverage (and your dependents' coverage) may be terminated irrevocably (retroactively to the extent permitted by law), and could be grounds for discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

Claims and Appeals Procedures

If there are any discrepancies between the claims and appeals procedures in this summary and the applicable plan summaries and documents provided by the carrier, then the carrier’s plan documents will govern.
Claim-Related Definitions

Claim
“Claim” is any request for plan benefits made in accordance with the plan’s claims-filing procedures, including any request for a service that must be pre-approved.

The Plan recognizes four categories of health benefit claims:

Urgent Care Claims
“Urgent care claims” are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for Medical benefits is urgent.

Pre-Service Claims
“Pre-service claims” are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-Service Claims
“Post-service claims” are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent Care Claims
“Concurrent care claims” are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an “urgent care claim,” “pre-service claim,” or “post-service claim,” depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination
If the Plan does not fully agree with your claim, you will receive an “adverse benefit determination” — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision.
An adverse benefit determination for disability claims or Medical benefit claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time. However, if the plan retroactively cancels coverage for failure to pay required contributions, that is not an adverse benefit determination.

**Initial Claim Determination**

The Plan has a specific timeframe to evaluate and respond to claims for benefits covered by ERISA. The relevant timeframe begins on the date the plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue. The timeframes outlined below apply may differ depending on the benefit and type of claim.

An adverse benefit determination notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan’s review procedures and the time limits applicable to such procedures; and
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

In the event of an adverse benefit determination for a health benefits claim, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request, and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

An adverse benefit determination notice for a disability claim will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - the views of medical or vocational experts obtained by the plan, without regard to whether the advice was relied upon for the adverse benefit determination; and
  - any Social Security Administration disability determination regarding the claimant presented to the Plan;
Either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and

A statement that reasonable access to and copies of all documents, records, and other information relevant to the claimant’s claim for benefits are available free of charge, upon request.

For health claims, the notice will also include information sufficient to identify the claim involved. This includes:

- An adverse benefit determination notice for an urgent care claim will include a description of the expedited review process. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.
- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount);
- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the plan’s standard used in denying the claim. For example, a description of the “medical necessity” standard;
- In addition to the description of the plan’s internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.
**Time Frames for Initial Claims Decisions**

Time frames generally start when the Plan receives a claim. Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to “days” means calendar days. Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account claims are considered non-urgent “post-service” claims.

<table>
<thead>
<tr>
<th>Medical, Dental, Vision, Onsite Clinic, Employee Assistance Plan, Health Care (and Limited Purpose) Flexible Spending Account Plans</th>
<th>Short-Term &amp; Long-Term Disability</th>
<th>Life, AD&amp;D, Business Travel, Critical Illness and Accident Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care Claims</strong></td>
<td><strong>Non-Urgent “Pre-Service” Claims</strong></td>
<td><strong>Non-Urgent “Post-Service” Claims</strong></td>
</tr>
<tr>
<td>Time frame for Providing Notice</td>
<td>Notice of determination (whether adverse or not) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.</td>
<td>Notice of determination (whether adverse or not) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days.</td>
</tr>
<tr>
<td><strong>Administrative Information</strong></td>
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<tr>
<th><strong>Medical, Dental, Vision, Onsite Clinic, Employee Assistance Plan, Health Care (and Limited Purpose) Flexible Spending Account Plans</strong></th>
<th><strong>Short-Term &amp; Long-Term Disability</strong></th>
<th><strong>Life, AD&amp;D, Business Travel, Critical Illness and Accident Insurance</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Extensions</strong></td>
<td><strong>Extensions</strong></td>
<td><strong>Extensions</strong></td>
</tr>
<tr>
<td>If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan’s receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.</td>
<td>The Plan has up to 15 days, if necessary due to matters beyond the Plan’s control, and must provide extension notice before initial 15-day period ends.*</td>
<td>The Plan has up to 30 days, if necessary due to matters beyond the Plan’s control. A second 30-day extension may also be permitted. The Plan must provide the extension notice before the initial 30-day period ends.*</td>
</tr>
<tr>
<td><strong>Period for Claimant to Complete Claim</strong></td>
<td><strong>Period for Claimant to Complete Claim</strong></td>
<td><strong>Period for Claimant to Complete Claim</strong></td>
</tr>
<tr>
<td>You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).</td>
<td>You have at least 45 days to provide any missing information.</td>
<td>You have at least 45 days to provide any missing information.</td>
</tr>
<tr>
<td><strong>Other Related Notices</strong></td>
<td><strong>Other Related Notices</strong></td>
<td><strong>Other Related Notices</strong></td>
</tr>
<tr>
<td>Notice that your claim is improperly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan).</td>
<td>Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan).</td>
<td>Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan).</td>
</tr>
</tbody>
</table>
Appealing a Claim

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart that follows. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator as listed in “Claims and Appeals Procedures” on page 130. If you don’t appeal on time, you lose your right to later object to the decision.

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

For disability claims and for Medical claims, the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert’s reputation for outcomes in contested cases, rather than based on the professional’s qualifications.
For disability claims and for Medical claims, prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the Medical claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your Medical benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed later in this section) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan’s control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception.

For a disability claim, if the Plan fails to strictly adhere to all the requirements of the disability claims and appeals process with respect to your disability benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may pursue legal remedies (as discussed later in this section) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan’s control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. If a court rejects your demand for immediate review based on the exceptions above, your claim will be considered as refiled on appeal upon receipt of the court’s decision, and the plan will notify you of the resubmission.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment under the Medical benefit plan, you may begin an expedited external review before the Plan’s internal appeals process has been completed.

The Claims Administrator will provide you with written notification of the Plan’s determination on review, within the time frames described in “Time Frames for Appeals Process” on page 139. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review; and
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.
For adverse benefit determinations under a health benefit under the Plan, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and

- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

For medical claim adverse benefit determinations, the notice will also include:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;

- A description of the Plan’s standard used in denying the claim. For example, a description of the “medical necessity” standard will be included;

- In addition to the description of the Plan’s internal appeal procedures, a description of the external review processes; and

- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

For adverse benefit determinations on disability claims, the notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - the views of medical or vocational experts obtained by the plan, without regard to whether the advice was relied upon for the adverse benefit determination; and
  - any Social Security Administration disability determination regarding the claimant presented to the Plan;

- A description of any applicable contractual limitations period, including the date on which the claim expires;

- Either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and

- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.
The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

Unless the right to an external review applies under the Medical benefit plan, all decisions are final and binding unless determined to be arbitrary and capricious by a federal district court of competent jurisdiction.

**External Review**

For Medical benefits, you may have the right to request an external review of a claim involving medical judgment, as determined by the external reviewer, or a coverage rescission. You must request the external review within four (4) months of the date you receive an adverse benefit determination. If your request for an external review is determined eligible for such a review, an independent organization will review the Claims Administrator’s decision and provide you with a written determination, as described in the plan summaries and carrier documents.

The external review decision is binding on you and the Plans, except to the extent other remedies are available under federal law.

The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that is not related to medical judgment or coverage rescission.

**Time Frames for Appeals Process**

The claims appeals procedures for a specific benefit are set forth in the plan summaries and documents provided by the carrier for that benefit. Please consult the specific carrier booklets for the specific benefit involved. Where not otherwise covered by the carrier booklets, the following procedures will apply. The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a “notice of benefit determination on review”) starts when the appeal is filed in accordance with the Plan’s procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to “days” mean calendar days. The Plan can require two levels of mandatory appeal review.
<table>
<thead>
<tr>
<th>Period for Filing Appeal</th>
<th>Medical, Dental, Vision, Employee Assistance Plan, Onsite Clinic &amp; Health Care (and Limited Purpose) Flexible Spending Account Plans</th>
<th>Short-Term &amp; Long-Term Disability</th>
<th>Life, AD&amp;D, Business Travel, Critical Illness and Accident Insurance Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Claims*</td>
<td>You have at least 180 days.</td>
<td>You have at least 180 days.</td>
<td>You have at least 180 days.</td>
</tr>
<tr>
<td>Non-Urgent Care Pre-Service Claims*</td>
<td>You have at least 180 days.</td>
<td>You have at least 180 days.</td>
<td>You have at least 60 days.</td>
</tr>
<tr>
<td>Non-Urgent Care Post-Service Claims*</td>
<td>You have at least 180 days.</td>
<td>You have at least 180 days.</td>
<td>You have at least 60 days.</td>
</tr>
<tr>
<td>Time frame for Providing Notice of Benefit Determination on Review</td>
<td>As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.</td>
<td>Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.</td>
<td>Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.</td>
</tr>
<tr>
<td></td>
<td>Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.</td>
<td>Within a reasonable period of time, but not later than 45 days after receipt of request for review.</td>
<td>Within a reasonable period, but not later than 60 days from receipt of request for review.</td>
</tr>
<tr>
<td>Medical, Dental, Vision, Employee Assistance Plan, Onsite Clinic &amp; Health Care (and Limited Purpose) Flexible Spending Account Plans</td>
<td>Short-Term &amp; Long-Term Disability</td>
<td>Life, AD&amp;D, Business Travel, Critical Illness and Accident Insurance Benefits</td>
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</tr>
<tr>
<td>Urgent Care Claims*</td>
<td>Non-Urgent Care Pre-Service Claims*</td>
<td>Non-Urgent Care Post-Service Claims*</td>
<td></td>
</tr>
<tr>
<td>Extensions</td>
<td>None.</td>
<td>None.</td>
<td>None.</td>
</tr>
</tbody>
</table>

You are required to exhaust the claims and appeals procedures described herein before filing suit against the Plan or any insurer. No legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review decision by the Claims Administrator has been rendered or deemed rendered. Any such action must be brought in federal district court in the state of Maryland.

**Protections Against Discrimination**

JHU complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. JHU does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

JHU provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in alternative formats (large print, audio, accessible electronic formats, etc.).

JHU 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 the JHU Office of Institutional Equity.
If you believe that JHU 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:

Office of Institutional Equity
Johns Hopkins University
Wyman Park Building, Suite 515
3400 North Charles Street
Baltimore, Maryland 21218

Telephone: 410-516-8075
General inquiry email: oie@jhu.edu
Disability Services and Accommodations email: oiedisability@jhu.edu
TTY: 711, MD Relay
Fax: 410-367-2665

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Office of Institutional Equity 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
Rom 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (1-800-537-7697 TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Contacts

For information about the benefits available to you, contact the Benefits Service Center via email at benefits@jhu.edu, or call 410-516-2000. Office hours are Monday through Friday, 8:30 am – 5:00 pm.

Johns Hopkins University at Eastern
Benefits Service Center
1101 East 33rd Street, Suite D200
Baltimore, MD 21218

Fax: 443-997-5820

The following is a list of resources for additional information about JHU’s benefits, policies, and programs.

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<th>Benefit Plan Contact</th>
<th>Phone Number</th>
<th>Call For...</th>
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</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td></td>
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<tr>
<td>CareFirst BlueCross BlueShield</td>
<td>877-691-5856</td>
<td>General customer service.</td>
</tr>
<tr>
<td><a href="http://www.carefirst.com">www.carefirst.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EHP (faculty and staff only)</td>
<td>800-261-2393 or 410-424-4450</td>
<td>General customer service.</td>
</tr>
<tr>
<td><a href="http://www.ehp.org">www.ehp.org</a></td>
<td></td>
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</tr>
<tr>
<td>BlueChoice</td>
<td>877-691-5856</td>
<td>General customer service.</td>
</tr>
<tr>
<td><a href="http://www.carefirst.com">www.carefirst.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>800-777-7902</td>
<td>General customer service (medical and prescription drug).</td>
</tr>
<tr>
<td><a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a></td>
<td></td>
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</tbody>
</table>
| Express Scripts               | 800-336-3862     | ▪ General customer service  
▪ Check formulary list for your drug  
▪ Find out more about mail order prescriptions |
<p>| <a href="http://www.express-scripts.com">www.express-scripts.com</a>       |                  |                                                  |
| <strong>Accident Insurance</strong>        |                  |                                                  |
| MetLife                       | 866-795-9362     | General customer service.                        |
| <a href="http://www.jhuvoluntarybenefits.com">www.jhuvoluntarybenefits.com</a>  |                  |                                                  |</p>
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<tr>
<th>Benefit Plan Contact</th>
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<td><strong>Critical Illness Insurance</strong></td>
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<tr>
<td>MetLife</td>
<td>866-795-9362</td>
<td>General customer service.</td>
</tr>
<tr>
<td><a href="http://www.jhuvoluntarybenefits.com">www.jhuvoluntarybenefits.com</a></td>
<td></td>
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<tr>
<td><strong>Dental</strong></td>
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<tr>
<td>Delta Dental</td>
<td>800-932-0783</td>
<td>▪ General customer service</td>
</tr>
<tr>
<td><a href="http://www.deltadentalins.com">www.deltadentalins.com</a></td>
<td></td>
<td>▪ Find an in-network dentist</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td></td>
<td></td>
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<tr>
<td>EyeMed</td>
<td>866-939-3633</td>
<td>▪ General customer service</td>
</tr>
<tr>
<td><a href="http://www.eyemed.com">www.eyemed.com</a></td>
<td></td>
<td>▪ To find an in-network optometrist</td>
</tr>
<tr>
<td>▪ Claims service</td>
<td></td>
<td>▪ Claims service</td>
</tr>
<tr>
<td><strong>Spending Accounts</strong></td>
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<td></td>
</tr>
<tr>
<td>WEX</td>
<td>866-451-3399</td>
<td>▪ General customer service</td>
</tr>
<tr>
<td><a href="http://www.wexinc.com">www.wexinc.com</a></td>
<td></td>
<td>▪ Claims service</td>
</tr>
<tr>
<td><strong>Life Insurance</strong></td>
<td></td>
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<tr>
<td>Securian Financial Group</td>
<td>866-293-6047</td>
<td>General customer service.</td>
</tr>
<tr>
<td><a href="http://www.securian.com">www.securian.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits Service Center</td>
<td>410-516-2000</td>
<td>Information in the event of a claim.</td>
</tr>
<tr>
<td><a href="http://www.hr.jhu.edu/benefits-worklife/">www.hr.jhu.edu/benefits-worklife/</a></td>
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<tr>
<td>Benefit Plan Contact</td>
<td>Phone Number</td>
<td>Call For...</td>
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<tr>
<td><strong>AD&amp;D (faculty and staff only)</strong></td>
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</tbody>
</table>
| Securian Financial Group www.securian.com | 866-293-6047 | ▪ General customer service  
▪ Emergency assistance in the United States  
▪ Emergency assistance while overseas |
| Benefits Service Center www.hr.jhu.edu/benefits-worklife/ | 410-516-2000 | Information in the event of a claim |
| **Dependent Life Insurance** | | |
| Benefits Service Center www.hr.jhu.edu/benefits-worklife/ | 410-516-2000 | Information in the event of a claim. |
| **Group Travel Insurance** | | |
| **Disability Insurance** | | |
| Lincoln Financial Group www.mylincolnportal.com (Code: JHUEE) | 888-246-4483 | Dedicated service line |
| **Wellness Program** | | |
| Healthy at Hopkins http://hr.jhu.edu/benefits-worklife/wellness-programs/ | 410-516-2000 | Information about wellness programs offered by JHU. |
▪ 410-955-6211 (East Baltimore) | Information about wellness programs offered by JHU. |
<table>
<thead>
<tr>
<th>Benefit Plan Contact</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td><strong>Employee Assistance Program</strong></td>
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<tr>
<td>Employee Assistance Program</td>
<td>443-997-7000</td>
<td>Assistance with personal problems, family issues, etc.</td>
</tr>
<tr>
<td><a href="https://hr.jhu.edu/benefits-worklife/support-programs/">https://hr.jhu.edu/benefits-worklife/support-programs/</a></td>
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<tr>
<td><strong>COBRA</strong></td>
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<tr>
<td>WEX (COBRA Administration and Billing</td>
<td>866-451-3399</td>
<td>▪ Assistance with COBRA questions</td>
</tr>
<tr>
<td><a href="http://www.wexinc.com">www.wexinc.com</a></td>
<td></td>
<td>▪ General customer service</td>
</tr>
<tr>
<td>Benefits and Worklife Service Center</td>
<td>410-516-2000</td>
<td>▪ Assistance with COBRA questions</td>
</tr>
<tr>
<td><a href="http://www.hr.jhu.edu/benefits-worklife/">www.hr.jhu.edu/benefits-worklife/</a></td>
<td></td>
<td>▪ General customer service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ More information about worklife programs</td>
</tr>
<tr>
<td><strong>JHU Benefits Services and Operations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WEX (Retiree, LTD and Special Billing</td>
<td>(866) 451-3399</td>
<td>General customer service for retiree health insurance, LTD and special billing.</td>
</tr>
<tr>
<td><a href="http://www.wexinc.com">www.wexinc.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits Service Center</td>
<td>410-516-2000</td>
<td>General assistance with Benefits.</td>
</tr>
<tr>
<td><a href="http://www.hr.jhu.edu/benefits-worklife/">www.hr.jhu.edu/benefits-worklife/</a></td>
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<tr>
<td><strong>Government Entities</strong></td>
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<tr>
<td>Internal Revenue Service</td>
<td>800-829-1040</td>
<td>Assistance with tax-related questions.</td>
</tr>
<tr>
<td><a href="http://www.irs.gov">www.irs.gov</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security Administration</td>
<td>800-772-1213</td>
<td>Assistance with questions about Social Security benefits and programs.</td>
</tr>
<tr>
<td><a href="http://www.ssa.gov">www.ssa.gov</a></td>
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<td>202-619-0724</td>
<td>Assistance with topics, programs, and services related to aging.</td>
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<td>Agency for Healthcare Research and Quality</td>
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## Appendix

This appendix is a complete list of all the Certificates of Coverage, Benefit Summaries and any additional documents that provide information about a benefit — for each of the benefit Plans that are incorporated by reference into this Summary Plan Description (SPD). These supplemental documents along with the information contained in this document constitute the SPD for the Johns Hopkins University benefit plans.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Links to Supporting Documents</th>
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<td><strong>Medical</strong></td>
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<td>Group Vision Plan Summary</td>
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Report of the Validation Errors.