The Johns Hopkins University Welfare Plan

EHP Classic Plan Summary Plan Description

January 1, 2020

Important Telephone Numbers

Claims or Coverage Questions	Johns Hopkins EHP JHU Office of Benefits Services	410-424-4450 or 800-261-2393 www.ehp.org 410-516-2000 benefits@jhu.edu
Care Management Program (Preauthorization of services)	Johns Hopkins EHP	410-424-4450

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EHP CLASSIC PLAN

General Information About Your Benefits

The EHP Classic Plan is one of the group health plans made available under the Johns Hopkins University Welfare Plan. The Welfare Plan is described in the Johns Hopkins University Health and Welfare Handbook.

The EHP Classic Plan is described in this Summary Plan Description (SPD). This EHP Classic Plan Summary Plan Description must be read together with the Health and Welfare Handbook for a complete description of your benefits. All eligibility rules for employees and dependents are contained in the Health and Welfare Handbook. The benefits described in this SPD are only provided for persons who are covered by the EHP Classic Plan, as determined in accordance with the Health and Welfare Handbook.

The EHP Classic Plan is administered by Johns Hopkins Employer Health Programs, Inc. (EHP).

This EHP Classic Plan SPD supersedes the description of the EHP Classic Plan contained in the Health and Welfare Handbook, effective for claims incurred on or after January 1, 2020.

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

The EHP Classic Plan

The EHP Classic Plan is designed to provide you and your covered dependents with quality health care services in the most cost effective settings. The EHP Classic Plan offers a wide range of health care benefits, including coverage for inpatient and outpatient hospital care, medical and surgical services, prescription drugs, vision care, mental health and substance use disorder services and preventive care benefits.

Network Providers

The EHP Classic Plan gives you access to The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General Hospital, Suburban Hospital, Sibley Memorial Hospital, Johns Hopkins All Children's Hospital, Mt. Washington Pediatric Hospital, and a Network of local and regional community hospitals. There are two parts to the Network:

- Providers that participate in the Johns Hopkins Employer Health Programs (EHP) Network.
- For services received outside the State of Maryland, you can go to providers that participate in the MultiPlan PHCS Network. For services received inside the State of Maryland, MultiPlan Network providers are only considered to be network providers if they also participate in the Johns Hopkins EHP Network. Any reference to EHP Network providers in this SPD means both EHP Network providers and MultiPlan PHCS Network providers.

You should ask your provider if they are in the EHP Network before you receive services in Maryland, or if they are in the MultiPlan PHCS Network before you receive services outside of Maryland. For a complete listing of EHP Network providers, please see the provider directory available at www.ehp.org, or call 410-424-4450 or 800-261-2393. For a complete listing of MultiPlan PHCS Network providers, please see the provider directory available at www.multiplan.com or call 866-980-7427.

Primary Care Physicians

You are encouraged (but not required) to designate a Primary Care Physician (PCP) to coordinate your medical care. However, you never need a referral from a PCP. (Certain services require preauthorization, as explained later in this SPD.) Having a designated PCP ensures that preventive services are addressed and allows you the opportunity for a relationship with your PCP and to feel comfortable with your choice of provider.

You can designate or change your PCP by calling an EHP Customer Service Representative at 1-800-261-2393 or 410-424-4450, or go to www.ehp.org and sign in to HealthLink@Hopkins to send a secure email to EHP. Your PCP change will become effective on the date you request the change.

Your designated PCP is responsible for helping to keep you well, providing routine treatment, or referring you to an EHP Network specialist when necessary. There are no claims to file — the EHP Network provider receives payment directly from the Plan. You may select a pediatrician as the designated PCP for your children.

Go online for the Johns Hopkins EHP provider search for PCPs, available at www.ehp.org. *You and your dependents may designate any listed PCP who is available.*

Two Ways to Receive Care

The EHP Classic Plan offers ***two*** ways to receive care. The higher level of benefits is paid for treatment by EHP Network providers. The lower level of benefits is paid for treatment by Out-of-Network providers. You do not have to designate a Primary Care Physician and you never need a referral. Certain services require preauthorization, as explained later in this SPD.

EHP Network Providers

If you receive treatment from an EHP Network provider, most services are covered at 80%, after meeting the annual deductible of $250 per person and $750 per family.

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

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

For services covered at 80%, you pay the remaining percentage until you reach an annual calendar year Out-of-Pocket Maximum of $2,000 per person and $6,000 per family. After you reach the Out-of-Pocket Maximum, benefits for covered services are paid at 100% of the charge for the remainder of that calendar year.

Out-of-Network Providers

The Plan pays benefits if you go to a provider outside of the Johns Hopkins EHP Network. You must first meet an annual deductible of $500 per person and $1,500 per family. After the deductible and any applicable copay, the Plan pays 70% of the Allowed Benefit (see **Payment Terms You Should Know** discussed below), and you pay the remaining 30%, until you reach an annual calendar year Out-of-Pocket Maximum of $4,000 per person and $12,000 per family. After you reach the Out-of-Pocket Maximum, benefits for covered services are paid at 100% of the Allowed Benefit for the remainder of that calendar

year. You are responsible for any amounts over the Allowed Benefit, and those amounts do not count towards the deductible or the Out-of-Pocket Maximum.

Payment Terms You Should Know

To understand how your benefits are paid, please refer to the following terms.

- **Allowed Benefit (AB)**: for any service or supply, the lesser of (1) the provider's actual charge or (2) the amount that would be allowed by Medicare, increased by a percentage determined by Johns Hopkins Employer Health Programs, not to exceed 150% of the amount that would be allowed by Medicare. If Medicare does not provide an allowance for a service or supply, then Allowed Benefit means the prevailing, reasonable fee paid to similar providers for the same service or supply in the same geographic area, as determined by Johns Hopkins Employer Health Programs. EHP Network providers will not charge more than the Allowed Benefit, but Out-of-Network providers can charge more and you are responsible for charges above the Allowed Benefit.

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

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

- **Deductible:** The amount you must pay each calendar year before the Plan begins to pay benefits for certain services.

  - For treatment by an EHP Network provider, the deductible is $250 per person and $750 per family.

  - For treatment by an Out-of-Network provider, the deductible is $500 per person and $1,500 per family.

  - The **Medical Benefits At-A-Glance** chart later in this SPD lists which services the deductible applies to.

  - Expenses incurred and applied to your EHP Network provider deductible apply to your Out-of-Network deductible, and vice versa.

  - Expenses incurred and applied to your deductible in October, November and December of a calendar year are also carried over and applied to the next calendar year’s deductible.

Expenses incurred by two or more persons can meet the family deductible. However, no one person will be required to satisfy more than the per-person deductible.

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

The **medical out-of-pocket maximum** applies to all your expenses under the EHP Classic Plan other than expenses under the ***Prescription Drug Benefit***. After you have paid the annual medical out-of-pocket maximum, the Plan pays any additional covered medical expenses at 100% for the remainder of that calendar year.

- The EHP Network annual medical out-of-pocket maximum is $2,000 per person and $6,000 per family.

- The Out-of-Network annual medical out-of-pocket maximum is $4,000 per person and $12,000 per family. You are still responsible for all amounts over the Allowed Benefit, and these amounts do not apply to the out-of-pocket maximum.

- Medical expenses incurred and applied to your EHP Network medical out-of-pocket maximum apply to your Out-of-Network medical out-of-pocket maximum, and vice versa.

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

The **prescription drug out-of-pocket maximum** applies to copays and coinsurance under the ***Prescription Drug Benefit***. After your prescription drug copays and coinsurance reach the annual prescription drug out-of-pocket maximum of $2,000 per person and $6,000 per family, you pay no copays or coinsurance for covered prescription drugs for the remainder of that calendar year.

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

Care Management Program

EHP CLASSIC PLAN

Before you can receive benefits for certain services and supplies under the EHP Classic Plan, you must have these services and supplies preauthorized by the EHP Care Management Program. Your EHP Network provider will request preauthorization for you. If you receive Out-of-Network care, you or your Out-of-Network provider must request preauthorization. Unless preauthorization is received, there is no coverage for the services and supplies in question.

The services and supplies that require preauthorization by the Care Management Program are indicated on the Medical Benefits At-A- Glance chart below.

Because medical treatments are constantly changing, Johns Hopkins Employer Health Programs can determine that preauthorization is required for additional services and supplies not shown on the Medical Benefits At-A-Glance chart. EHP Network providers will be notified of additional services and supplies that require preauthorization, and will request preauthorization as needed. Before you receive Out-of-Network care, you or your Out-of-Network provider must check with Johns Hopkins Employer Health Programs to see if the services or supplies involved require preauthorization, and if so must request preauthorization.

The purpose of the Care Management Program is to assure you receive quality care that is medically necessary and appropriate. The Program also strives to protect you from significant, and sometimes unnecessary, health care expenses. *The Care Management Program is not intended to diagnose or treat your medical conditions*. Rather, the Care Management Program will coordinate the medical care services you receive across the continuum of care.

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

Health and Wellness Programs

Johns Hopkins Employer Health Programs is committed to partnering with you to achieve better health. Whether it is guiding you further along the prevention path or stepping in when you need extra support, Johns Hopkins EHP is ready to assist you at any stage of your health journey. From education and encouragement to one-on-one outreach and care coordination, EHP can help you take the small steps to achieve big change.

Preventive Care

EHP CLASSIC PLAN

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

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

The right preventive care at every stage of life can help you stay healthy, avoid or delay the onset of disease, or keep a condition you may already have from becoming worse. EHP Classic Plan members and their covered family members may self-refer into these programs by going to https://www.ehp.org/plan-benefits/health-programs and resources/, or by calling EHP Customer Service.

Quality

The best way to receive consistent, quality care is by establishing a relationship with a primary care provider or PCP. PCPs help guide all your care including specialists, lab work and prescriptions and focus on preventing problems before they begin. Using your PCP's office as your first contact for most medical needs ensures you get the care you need when you need it, leading to better health, better communication and better results.

PCPs play a large role in keeping you healthy for the long run. To find a PCP, go to www.ehp.org and search for primary care providers at Find a Provider.

Care Coordination

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

- **Transition of Care** -- hospital transition of care coordinators will help ensure you have everything you need in place when you leave the hospital.

- **Complex Care** -- if you are ever faced with a serious medical event or a long-term health condition, your care coordinator can provide support for a variety of complex health concerns or conditions.

- **Behavioral Health Care** -- if you are living with a mental health condition such as depression, autism spectrum disorder, anxiety or addiction, your EHP Classic Plan benefits can include access to confidential care coordination support.

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

If you would like to refer yourself, or if you have any questions about Care Coordination Programs, please contact populationhealth@jhhc.com, or call 800-557-6916, Monday-Friday 8 a.m. – 5 p.m.

Health Coach Program

Another program to assist you in managing your health is the Health Coach program. This free, voluntary program encourages interest in healthier lifestyles. If you have well managed chronic conditions or are at risk for developing chronic conditions, you may benefit from this program. Risk factors may include hypertension, high cholesterol, obesity, smoking and pre-diabetes.

Health coaching provides one-on-one assistance to guide you in adopting healthy lifestyle behaviors. Program duration is 6 to 10 months and sessions are conducted by telephone each month. Primary areas of interest for enrolling in the program are weight loss, nutrition, fitness, stress management and tobacco cessation. The health coach will work with you on monthly goal setting and create an individualized action plan based on your needs. Throughout the program, various assessments are taken to evaluate your progress, health status, and program satisfaction, and modifications to your action plan are made as needed.

You may self-refer into the program or be referred by your health care provider or case manager. If you are appropriate for the program you will be contacted by your assigned health coach.

Your eligibility for benefits under the EHP Classic Plan is not affected if you do not participate in the program or if you withdraw from the program after you start.

We encourage you to take advantage of this free program to assist you in managing your health. You may contact the program at healthcoach@jhhc.com or call 1-800-957-9760.

EHP Customer Service

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

If you have a question, EHP Customer Service Representatives are available Monday through Friday, from 8 a.m. to 5 p.m., at 1-800-261-2393 or 410-424-4450.

A Johns Hopkins EHP Classic Plan identification card will be issued to you and each of your covered

dependents. Carry your identification card with you at all times and show it to your health care provider whenever you receive medical care.

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

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

What's Covered by the EHP Classic Plan

Medical Benefits At-A-Glance

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

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
CALENDAR YEAR DEDUCTIBLE		
Per person	$250	$500
Per family	$750	$1,500
MEDICAL OUT-OF-POCKET MAXIMUM (deductible, coinsurance and medical copays; excludes prescription drug coinsurance)		
Per person	$2,000	$4,000
Per family	$6,000	$12,000
PENALTY FOR FAILURE TO OBTAIN PREAUTHORIZATION		
	Not applicable	Denial of benefits
1. TREATMENT OF ILLNESS OR INJURY		
Primary care office visit for medical treatment, adult and pediatric	80% after deductible	70% of AB after deductible
Primary care office visit for GYN treatment	80% after deductible	70% of AB after deductible
Specialty care office visit	80% after deductible	70% of AB after deductible
Diagnostic services and treatment in the office	80% after deductible	70% of AB after deductible
Specialty medication injections, materials and serum	80% after deductible	70% of AB after deductible

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

Only medically necessary services and supplies are covered.

"AB" means Allowed Benefit, which is explained under **Payment Terms You Should Know**, earlier in this SPD.

MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
2. PREVENTIVE SERVICES		
General preventive exam (adult physical, GYN and well child care)	100%, no deductible	70% of AB, no deductible
Diagnostic services for exam	100%, no deductible	70% of AB, no deductible
Mammogram and well-woman care	100%, no deductible	70% of AB, no deductible
Screening colonoscopy	100%, no deductible	70% of AB, no deductible
Routine hearing exam	80% after deductible	70% of AB after deductible
Dermatological screening, one per plan year	100%, no deductible	70% of AB, no deductible
3. IMMUNIZATIONS		
As recommended by Centers for Disease Control and Prevention, or as required for travel	100%, no deductible	70% of AB, no deductible
4. PRESCRIPTION DRUGS		
Up to 30-day supply; No copay for certain generic contraceptives	Retail Pharmacy $10 copay – generic 20% coinsurance ($30 min, $45 max) – brand formulary (1) 25% coinsurance ($60 min, $100 max) – brand non-formulary (1) (2)	
Up to 90-day supply for maintenance drugs; No copay for certain generic contraceptives	Mail Order: $25 copay – generic 20% coinsurance ($75 min, $112.50 max) – brand formulary (1) 25% coinsurance ($150 min, $250 max) – brand non-formulary (1) (2)	
5. ALLERGY TESTS AND PROCEDURES		
Allergy tests	80% after deductible	70% of AB after deductible
Desensitization materials/serum	80% after deductible	70% of AB after deductible
6. LABORATORY		
Laboratory tests, including pathology	80% after deductible	70% of AB after deductible

(1) If a generic drug is available, you must pay the generic copay plus the difference in cost between the brand and the generic drug.
(2) If a brand formulary drug is available, you must pay the brand formulary coinsurance plus the difference in cost between the brand non-formulary and the brand formulary drug.

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

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MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
7. RADIOLOGY PROCEDURES		
Advanced imaging, including CT scans, PET scans and MRIs	80% after deductible	70% of AB after deductible
All other imaging studies, including x-rays and ultrasound	80% after deductible	70% of AB after deductible
8. SURGICAL PROCEDURES		
Professional charges for inpatient and outpatient surgery; preauthorization required for inpatient surgery	80% after deductible	70% of AB after deductible
Professional charges for surgery in provider's office	80% after deductible	70% of AB after deductible
Surgical treatment for morbid obesity; preauthorization required	80% after deductible	70% of AB after deductible
9. REPRODUCTIVE HEALTH		
Physician office visits (for prenatal care only)	80% after deductible	70% of AB after deductible
Facility charges for inpatient maternity care, including nursery; preauthorization required	$250 copay, then 80% after deductible	$250 copay, then 70% of AB after deductible
Professional charges for inpatient maternity care and delivery	80% after deductible	70% of AB after deductible
Birthing centers (facility charges)	80% after deductible	70% of AB after deductible
Birthing centers (professional fees)	80% after deductible	70% of AB after deductible
Voluntary sterilization, female	100%, no deductible	100% of AB, no deductible
Voluntary sterilization, male	80% after deductible	70% of AB after deductible
Interruption of pregnancy	80% after deductible	70% of AB after deductible
Infertility treatment; preauthorization required	80% after deductible	70% of AB after deductible

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MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
10. URGENT CARE CENTER		
Physician visit	100% after $50 copay, no deductible	100% of AB after $50 copay, no deductible
Diagnostic services and treatment	100%, no deductible	100% of AB, no deductible
11. EMERGENCY SERVICES		
Emergency room, facility fees	100%, no deductible, after $100 copay (waived if admitted)	100% of AB, no deductible, after $100 copay (waived if admitted)
Emergency room, professional fees	80% after deductible	80% of AB after deductible
12. AMBULANCE TRANSPORTATION		
Ground or air transportation when medically necessary; preauthorization required for air ambulance in non-emergencies	80% after deductible	70% of AB after deductible
13. HOSPITAL CARE		
Inpatient facility care (semi-private, unless private room is medically necessary); preauthorization required	$250 copay per admission, then 80% after deductible	$250 copay per admission, then 70% of AB after deductible
Inpatient professional services	80% after deductible	70% of AB after deductible
Skilled nursing/acute rehabilitation facility (120 days per calendar year combined maximum; preauthorization required)	80% after deductible	70% of AB after deductible
Outpatient professional services	80% after deductible	70% of AB after deductible
Outpatient surgery facility charges	100%, no deductible	70% of AB after deductible
Observation care professional services	80% after deductible	80% of AB after deductible
Observation care facility charges	$100 copay, then 100%, no deductible (copay waived if admitted)	$100 copay, then 100% of AB, no deductible (copay waived if admitted)
14. CHEMOTHERAPY/ RADIATION THERAPY		
Physician visit	80% after deductible	70% of AB after deductible
Materials and treatment	80% after deductible	70% of AB after deductible

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

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MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
15. ACUPUNCTURE		
For anesthesia, pain control and therapeutic purposes (15 visits per calendar year combined maximum)	80% after deductible	70% of AB after deductible
16. HOME HEALTH CARE		
90 visits per calendar year combined maximum; preauthorization required	100%, no deductible	70% of AB after deductible
17. HOSPICE CARE		
Inpatient and home; preauthorization required	80% after deductible	70% of AB after deductible
18. INFUSION THERAPY		
Home infusion therapy; preauthorization required	80% after deductible	70% of AB after deductible
Outpatient infusion therapy	80% after deductible	70% of AB after deductible
19. SPEECH THERAPY		
30 visits per calendar year combined maximum; preauthorization required	80% after deductible	70% of AB after deductible
20. PHYSICAL/OCCUPATIONAL THERAPY		
Licensed therapist only (including chiropractor with PT privileges); 45 visits per calendar year combined maximum	80% after deductible	70% of AB after deductible
21. HYPERBARIC OXYGEN THERAPY		
Preauthorization required	80% after deductible	70% of AB after deductible

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

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MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
22. DIALYSIS		
Services and supplies; preauthorization required	80% after deductible	70% of AB after deductible
23. HABILITATIVE SERVICES		
Under age 19 only; preauthorization required	80% after deductible	70% of AB after deductible
24. CHIROPRACTIC CARE		
Restricted to initial exam, X-rays and spinal manipulations	80% after deductible	70% of AB after deductible
25. DURABLE MEDICAL EQUIPMENT AND SUPPLIES		
Non-custom equipment and medical supplies	80% after deductible	70% of AB after deductible
Custom equipment/wheelchairs; preauthorization required	80% after deductible	70% of AB after deductible
Insulin pumps, glucose monitors and related supplies	80% after deductible	70% of AB after deductible
Breast pumps (standard) and related supplies	100%, no deductible	70% of AB after deductible
Contraceptive devices	100%, no deductible	70% of AB after deductible
Custom molded orthotics; preauthorization required	80% after deductible	70% of AB after deductible
Prosthetic devices; preauthorization required	80% after deductible	70% of AB after deductible
Hearing aids for children under 26; preauthorization required	80% after deductible	70% of AB after deductible
26. NUTRITION COUNSELING		
Preauthorization required after two visits combined per calendar year	80% after deductible	70% of AB after deductible

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

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

MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
27. MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT		
Inpatient facility charges; preauthorization required	$250 copay per admission, then 80% after deductible	$250 copay per admission, then 70% of AB after deductible
Inpatient professional fees	80% after deductible	70% of AB after deductible
Outpatient facility charges	80% after deductible	70% of AB after deductible
Outpatient professional fees	80% after deductible	70% of AB after deductible
Biofeedback; preauthorization required	80% after deductible	70% of AB after deductible
Partial hospital facility days/intensive outpatient program; preauthorization required	80% after deductible	70% of AB after deductible
Medication management	80% after deductible	70% of AB after deductible
Methadone treatment	80%, no deductible	70% of AB after deductible
Psychological and behavioral testing and procedures; preauthorization required	80% after deductible	70% of AB after deductible
28. PULMONARY REHABILITATION		
Preauthorization required	80% after deductible	70% of AB after deductible
29. CARDIAC REHABILITATION		
Preauthorization required	80% after deductible	70% of AB after deductible

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

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

COVERED SERVICES AND SUPPLIES

Covered Services and Supplies

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

A medically necessary service or supply is one that the Plan Administrator determines:

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

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

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

In General

The EHP Classic Plan covers the following services and supplies, when medically necessary and subject to any conditions or limitations described elsewhere in this SPD:

- Abortion
- Acupuncture for anesthesia, pain control and therapeutic purposes, when provided by a licensed acupuncturist (Care Management preauthorization required)
- Ambulance services – see below
- Anesthetics and oxygen, and their administration
- Artificial limbs and eyes
- Biofeedback therapy (Care Management preauthorization required)

- Birthing facilities
- Blood products for which a charge is made
- Breast pumps, standard only
- Casts, splints
- Chiropractic care for misalignment or partial dislocation of or in the vertebral column and correction by manual or mechanical means of nerve interference
- Consultation services by a specialist in the medical field for which the consultation relates; staff consultation required by the facility is not covered
- Contraceptive devices provided for in comprehensive guidelines supported by the Health Resources and Services Administration and approved by the Food and Drug Administration
- Convalescent facility care and home health care (Care Management preauthorization required)
- Cosmetic/reconstructive surgery when due to:
  - accidental injury or illness that is or would be covered by the Plan
  - correction of a congenital malformation of a child
  - treatment for morbid obesity – see "Obesity treatment" below
  - as provided for under ***Women's Health and Cancer Rights Act*** below in this SPD.
- Dental services if rendered as initial treatment as a result of an accident causing injury to sound natural teeth and treatment is provided within 48 hours of the accident
- Dermatological screening, once per plan year
- Diabetic supplies
- Diagnostic X-rays and laboratory services
- Dialysis (Care Management preauthorization required)
- Doctors' (including surgeons') fees for treatment of illness or injury
- Doctors' fees and hospital charges for maternity care

COVERED SERVICES AND SUPPLIES

- Doctors' fees for office visits

- Durable medical equipment, including wheelchairs. (Care Management preauthorization required for custom equipment.) Durable medical equipment is medical equipment which:

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

- Emergency Services – see below

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

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

- Gastric bypass surgery – see "Obesity treatment" below

- Gender affirmation – see below

- Habilitative Services – see Physical, Occupational and Speech Therapy below

- Hearing aids for dependent children under age 26. The aids must be prescribed, fitted and dispensed by a licensed audiologist. Replacement aids are available only once every three years (Care Management preauthorization required);

- Home health care – see below

- Hospice care – see below

- Hospital charges for covered semi-private room and board and other hospital-provided services and supplies (Care Management preauthorization required for admission)

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Immunizations related to travel that are approved by the Centers for Disease Control and Prevention guidelines for the countries to be visited
- Infertility treatment – see below
- Laboratory tests
- Maternity benefits – see below
- Medical and modified foods – see below
- Midwifery services
- Newborn care
- Nursing services (professional) by a registered nurse or licensed practical nurse who is not a close relative (spouse, child, grandchild, brother, sister, brother-in-law, sister-in-law, parent, or grandparent) of the patient
- Nutrition counseling
- Obesity treatment – see below
- Out-Of-Area Care – see below
- Outpatient surgical center
- Physical, occupational and speech therapy – see below
- Preventive care for adults, children and adolescents, including evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. No cost sharing applies to this preventive care from an EHP Network provider.
- Prosthetic devices and orthotics that are integral to the device (Care Management preauthorization required)

- Rehabilitation services (Care Management preauthorization required)
- Second surgical opinions
- Skilled nursing and rehabilitation facility care – see below
- Surgical dressings and medical supplies
- Surgical procedures (Care Management preauthorization required for inpatient procedures)
- Telephone consultation charges, if the consultation is medically necessary for treatment of a condition otherwise covered by the Plan
- Temporomandibular Joint Syndrome (TMJ) treatment and/or orthognathic surgery, limited to physical therapy, surgery and ortho devices such as mouthguards and intraoral devices (excludes orthodontics and prosthetics)
- Tobacco cessation intervention, as covered by United States Preventive Services Task Force preventive care recommendations with a rating of A or B
- Transplants – see below
- Vasectomies and tubal ligations
- Vision benefits – see below
- Well-child care, including evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. No cost sharing applies to this preventive care from an EHP Network provider.
- Well-woman care, including evidence-informed preventive care and screenings for women provided for in comprehensive guidelines supported by the Health Resources and Services Administration. No cost sharing applies to this preventive care from an EHP Network provider.
- X-ray, radium, and radioisotope treatment.

Following are descriptions of other services and supplies covered by the EHP Classic Plan.

Prescription Drug Benefits

Prescription drug coverage is offered through Express Scripts. In accordance with the Express Scripts Pharmacy Benefit Manager Agreement, the EHP Classic Plan covers prescription drugs as follows:

- ***Generic*** drugs contain the same active ingredients as their brand name equivalents. Your cost will be lowest with a prescription for a generic drug, which are only subject to a small copay.

- ***Formulary brand name*** drugs are subject to a coinsurance payment that is greater than the generic copay. If a generic drug is not available, your physician will likely prescribe a formulary brand name drug.

- ***Non-formulary brand name*** drugs are generally new drugs or drugs that have a more cost effective generic or brand name equivalent. Non-formulary drugs have the highest coinsurance payment. If your physician believes that there are special reasons you should use a non-formulary brand name drug, they can request a coverage review. Or, you can call Express Scripts Member Services to request a review of your coverage.

To determine if your brand name drug is on the formulary list, go to www.Express-Scripts.com or call 1-800-336-3862.

The amount of your copay or coinsurance is set forth on the ***Medical Benefits-At-A-Glance*** chart earlier in this SPD.

You may purchase your prescriptions either through a participating retail pharmacy or through the mail order program.

- ***Retail***: You can receive up to a 30 day supply of your prescription drug when you purchase it through a participating retail pharmacy. Take your Express Scripts ID card to a participating pharmacy, which will fill your prescription. This is the right choice for prescription drugs you take on a short term basis, such as an antibiotic.

- ***Mail order***: Mail order offers both convenience and cost savings if you take maintenance prescription drugs. You are encouraged (but not required) to use the mail-order program for maintenance drugs. If you use the mail order program, you can receive up to a 90 day supply of your prescription and usually pay less than if you obtained a 90 day supply at a retail pharmacy. In addition, with the mail order program, you have the convenience of direct delivery to your home. This is the right choice for medications you take on a regular basis, such as medications used to treat an ongoing condition. Go to www.express-scripts.com for more information about the mail order program and to obtain the order form. You may also call 1-800-336-3862.

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

Annual Out-of-Pocket Maximum

The annual calendar year Out-of-Pocket Maximum that applies to prescription drug copays and coinsurance is $2,000 per person and $6,000 per family. Once you meet your Out-of-Pocket Maximum, the Plan pays 100% of your covered prescription drug expenses for the remainder of the year. You are still responsible for paying for any uncovered expenses.

Mandatory Generic and Formulary Drugs

If a generic drug is available but you purchase a brand name drug, you must pay the generic copay plus the difference in cost between the brand name and the generic drug.

If a brand name formulary drug is available but you purchase a non-formulary drug, you must pay the brand formulary coinsurance plus the difference in cost between the brand non-formulary and the brand formulary drug.

The difference in cost payment does not count towards your annual Out-of-Pocket Maximum.

Drug Quantity Management

To ensure that the most cost effective product strength is prescribed and to reduce waste, certain prescription drugs may be covered with quantity limits. For example, if only a certain quantity of a drug is indicated based on your condition, but your prescription exceeds the indicated quantity, pre-approval may be required by Express Scripts.

Step Therapy

Step therapy requires you to try lower cost prescription drugs before using drugs that cost more. If your prescription drug requires step therapy, you must try a "step one" drug before using a "step two" (or "step three") drug. "Step one" drugs are proven to be safe, effective and affordable and provide the same health benefits as more expensive drugs but at a lower cost to you and the Plan.

Prior Authorization

Some prescription drugs require prior authorization before they are covered, to ensure that the prescription is effective for your condition. Failure to obtain prior authorization will result in the prescription drug not being covered. Prior authorization may be required for prescription drugs that

have potentially dangerous side effects, are harmful when combined with other drugs, are often misused, are prescribed when less expensive drugs are as effective, or are specialty medications to treat specific diseases and require characteristics to help assess whether the drug will be effective.
To find out if a prescription drug requires prior authorization, go to www.express-scripts.com, select "Price a medication" under "Manage Prescriptions", and search for your prescription. On the results page, select 'View coverage notes" to see coverage details.

If your prescription drug needs prior approval, your physician will need to contact Express Scripts at 1-888-406-1213 to begin the approval process.

What's Not Covered

No prescription drug benefits will be paid for the following:

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

COVERED SERVICES AND SUPPLIES

Emergency Services

If you have a medical emergency, you should go to the nearest medical facility for immediate care.

Emergency Room

Medically necessary treatment by an emergency room (hospital or freestanding) is covered under the EHP Network provider benefit regardless of whether or not the emergency room participates in the EHP Network. Emergency room facility charges are covered in full, after a $100 copay. The copay is waived if you are admitted. No deductible applies for the treatment in the emergency room, but the deductible does apply if you are admitted to the hospital. If you go to an Out-of-Network emergency room, the EHP Classic Plan will not pay more than the Allowed Benefit for your treatment.

If you are admitted to an Out-of-Network hospital from the emergency room, and you can be moved to an EHP Network facility but you choose not to be moved, then services and supplies provided after you can be moved will be paid under the Out-of-Network benefit at 70% of the Allowed Benefit, after the deductible.

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

Urgent Care Center

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

If you go to an EHP Network urgent care center, your care will be covered at 100%, after a $50 copay.

If you go to an Out-of-Network urgent care center, your care will be covered at 100% of the Allowed Benefit, after a $50 copay. You are responsible for any amounts over the Allowed Benefit.

The deductible does not apply to treatment at an EHP Network or Out-of-Network urgent care center.

Out-Of-Area Care and Coverage for Students

The following **Out-of-Area Care** rules apply when you are travelling outside the EHP Network service area and need medical care that is not covered by the **Emergency Services** provisions described above. The following **Out-of-Area Care** rules apply based on whether care is foreseeable

or unforeseeable. ***Unforeseeable*** care means medical treatment or prescription drugs received before it is safe to return to the EHP Network service area and that could not have reasonably been anticipated before leaving the area. ***Foreseeable*** care means all other medical treatment or prescription drugs.

Claims for ***unforeseeable*** medical care or prescription drugs received while outside the EHP Network service area will be paid on the same terms as apply to care received from an EHP Network provider. However, benefits are calculated based only on the Allowed Benefit for the care received. In addition to any copay or coinsurance that might apply, you are responsible for all charges above the Allowed Benefit. Remember that a MultiPlan provider is an in-network provider and therefore will not charge you above the Allowed Benefit.

Claims for ***foreseeable*** out-of-area medical care from a MultiPlan provider will be paid under the EHP Network benefit. Claims for ***foreseeable*** out-of-area medical care from a non-MultiPlan provider will be covered at the Out-of-Network benefit level.

If your covered child goes to school outside the EHP Network service area, care received for medical treatment is covered under the **Out-of-Area Care** rules.

You (or someone on your behalf) must notify EHP at 410-424-4450 or 800-261-2393 of any Out-of-Area Care that results in an inpatient hospitalization within 48 hours after admission. If notice is not given on time, coverage may be denied.

Ambulance Services

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

- Because of an emergency medical situation (defined above under Emergency Services), it is medically necessary to transport you to the hospital.
- It is medically necessary to transport you from a hospital as an inpatient to another hospital, because:
  - The first hospital lacks the equipment or expertise necessary to care for you;
  - You are transported directly from a hospital to a skilled nursing/rehabilitation facility; or
  - As determined medically appropriate by the Care Management Program.
- You are medically stable and wish to transfer from a facility that is not an EHP Network facility to a facility that is an EHP Network facility.

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

not be covered.

In no event will the Plan pay more than the Allowed Benefit for air ambulance transportation.

Vision Benefits

The EHP Classic Plan covers optometry and ophthalmology vision exams through the Johns Hopkins Routine Vision Care Network. The Plan does not cover vision exams from Out-of-Network providers. Glasses, contact lenses and contact lens fitting fees are not covered.

One vision exam every 24 months is covered in full, with no deductible.

For a complete listing of Johns Hopkins Routine Vision Care Network providers, refer to the Vision section of the EHP provider search, available on www.ehp.org, or contact EHP Customer Service at 410-424-4450.

Maternity Benefits

The EHP Classic Plan provides benefits during your pregnancy and delivery.

The Plan covers 80% of your prenatal care and routine tests after the deductible when care is provided by an EHP Network OB/GYN. Midwife delivery services provided by a licensed midwife are also eligible for coverage.

Facility charges for delivery at an EHP Network licensed birthing center are covered at 80%, after the deductible. Professional charges are covered at 80%, after the deductible.

Facility charges for delivery at an EHP Network hospital are covered at 80%, after a $250 copay and the deductible. Professional charges are covered at 80%, after the deductible.

Care received from an Out-of-Network OB/GYN and Out-of-Network hospital or birthing center is covered at 70% of the Allowed Benefit, after the deductible, and you are responsible for any remaining charges. You must pay a $500 copay for a hospital admission. Midwife delivery services provided by a licensed midwife are also eligible for coverage.

The EHP Classic Plan provides maternity benefits for a mother and newborn child for hospital stays up to:

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

If the doctor and new mother agree that the stay does not need to be 48 (or 96) hours, the new mother and baby may leave the hospital as soon as it is medically approved. If the stay is to be longer than 48 hours (or 96 hours), Care Management must preauthorize the additional time.

Infertility Treatment

Infertility treatment (such as artificial insemination (AI), intrauterine insemination (IUI) and in-vitro fertilization, gamete intrafallopian transfer and zygote intrafallopian transfer (IVF, GIFT, ZIFT)) is available for female employees and covered female spouses/domestic partners. The following requirements apply:

- Care Management must preauthorize treatment, which must be provided on an outpatient basis;
- There must be a physician recommended treatment plan and a medical diagnosis of infertility;
- IVF/GIFT/ZIFT treatment must be provided at a medical facility that conforms to The American College of Obstetricians and Gynecologists guidelines for IVF clinics or The American Fertility Society minimal standards for programs of IVF;
- The order of infertility treatment options must follow a logical succession of medically appropriate and cost-effective care, including where appropriate attempting AI/IUI before attempting IVF/GIFT/ZIFT;
- There is a $100,000 lifetime dollar limit for all infertility treatment combined including prescription drugs, lab work and X-rays; this maximum applies per employee, not per spouse/domestic partner;
    - No lifetime dollar limit applies to charges for infertility testing, infertility counseling, and AI/IUI. However, these charges do count against the lifetime dollar limit for all other infertility treatment;
- There is a maximum of six attempts per live birth for AI/IUI;
- There is a maximum of three attempts per live birth for IVF/GIFT/ZIFT;
- Expenses connected with obtaining donor sperm/eggs are not covered, unless the covered person's sperm/eggs are not viable and donor sperm/eggs are recommended as part of the treatment plan;
- Expenses for acquisition, freezing, storing or thawing of sperm or eggs, whether or not from a donor, are not covered; coverage is provided for freezing or thawing (but not storage) of embryos;
- Infertility must not be related to a previous sterilization by you or your spouse/domestic partner;
- No coverage is provided for surrogate motherhood or gestational carrier purposes;
- The husband/domestic partner's sperm and the birth mother's egg must be used, unless there is a documented medical condition unrelated to age whereby use of the husband/domestic partner's sperm and/or the birth mother's egg is not possible;
- Medications required to be taken by the husband/domestic partner are only covered if the husband/domestic partner is covered by the Plan.

Medical and Modified Foods

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

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

The EHP Classic Plan covers amino acid-based elemental formula, regardless of delivery method, if the patient’s physician states in writing that the formula is medically necessary for the treatment of one of the following diseases or disorders:

- Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins;
- severe food protein induced enterocolitis syndrome;
- eosinophilic disorders, as evidenced by the results of a biopsy; or
- impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Obesity Treatment

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

- Surgical treatment for morbid obesity when Body Mass Index (BMI) (weight in kilograms/height in meters squared) is greater than 40, or equal to or greater than 35 with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes. Care Management preauthorization is required.

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

Women's Health and Cancer Rights Act

The EHP Classic Plan provides benefits for participants electing breast reconstruction in connection with a mastectomy. These include:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to provide a symmetrical appearance, and
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The manner of coverage is determined in consultation with the attending physician and patient. 3-D nipple tattooing of a reconstructed breast is also covered, but only if the tattoo artist is recommended by the provider of the reconstructive surgery, and possesses a license to provide tattoos if a license is required. Normal plan copays, coinsurance and lifetime maximums will apply.

Gender Affirmation

The EHP Classic Plan covers gender affirmation treatment for members as follows.

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

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

Physical, Occupational and Speech Therapy

The EHP Classic Plan covers physical, occupational and speech therapy provided by a licensed physical, occupational or speech therapist, or by a chiropractor with physical therapy privileges, that is required because of an illness or accidental injury.

Physical, occupational and speech therapy is also covered if required for the treatment of a person under age 19 with a congenital or genetic birth defect in order to enhance the person's ability to function. Congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect, and includes autism or an autism spectrum disorder, cerebral palsy, intellectual

disability, Down syndrome, spina bifida, hydroencephalocele, and congenital or genetic developmental disabilities. Unless caused by a congenital or genetic birth defect, treatment of stuttering, articulation disorders, tongue thrust, lisping and occupational, physical and speech maintenance therapy are not covered.

Home Health Care

All home health care services must be preauthorized by ***Care Management****.*

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

Home health care services and supplies must be provided by a licensed health care organization to be covered. No benefits are paid for services performed by a close relative or anyone living in your household. Each home health care visit is limited to four hours. Up to 90 home health care visits per calendar year are covered.

The Plan pays 100% of the charges for covered home health care services (excluding home infusion therapy) received from EHP Network providers, with no deductible. The Plan pays 80% of covered charges for home infusion therapy, after the deductible.

The Plan pays 70% of the Allowed Benefit, after the deductible, for covered services (including home infusion therapy) received from Out-of-Network providers and you are responsible for any remaining charges.

Covered home health care services include:

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

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

- ♦ Domestic or housekeeping services;
- ♦ Rental or purchase of equipment or supplies;
- ♦ Meals-on-wheels or other similar food arrangements;
- ♦ Care provided in a nursing home or skilled nursing/rehabilitation facility (see ***Skilled Nursing/Rehabilitation Facility Care*** discussed next);
- ♦ More than 90 visits per calendar year;
- ♦ Home care for mental health conditions; and
- ♦ Custodial care.

Skilled Nursing/Rehabilitation Facility Care

Your stay in a skilled nursing/rehabilitation facility must be preauthorized by ***Care Management****.*

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

The Plan pays 80% of the charges, after the deductible, for stays in an EHP Network skilled nursing/rehabilitation facility.

The Plan pays 70% of the Allowed Benefit, after the deductible, for stays in an Out-of-Network skilled nursing/rehabilitation services facility and you are responsible for any remaining charges.

Covered skilled nursing/rehabilitation facility services include:

- ♦ Room and board;
- ♦ Use of special treatment rooms;
- ♦ X-ray and laboratory examinations;
- ♦ Physical, occupational or speech therapy;
- ♦ Oxygen and other gas therapy;
- ♦ Drugs, biological solutions, dressings and casts; and
- ♦ Short term acute rehabilitation.

The patient's physician must prescribe care in a skilled nursing/rehabilitation facility and the patient must be under a physician's supervision throughout the stay. Charges will not be covered for more than 120 days per calendar year.

In order to be covered by the EHP Classic Plan, a skilled nursing/rehabilitation facility may not:

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

Hospice Care

Hospice care must be preauthorized by ***Care Management****.*

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

The Plan pays 80% of the charges for covered hospice care services from EHP Network providers, after the deductible.

The Plan pays 70% of the Allowed Benefit, after the deductible, for covered hospice care services from Out-of-Network providers and you are responsible for any remaining charges.

Covered hospice care services include:

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

Hospice care services ***do not*** include the following:

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

Transplants

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

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

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

No benefits will be paid for the following:

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

Mental Health and Substance Use Disorder Treatment

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

COVERED SERVICES AND SUPPLIES

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

Like any other medical treatment, the Care Management Program must preauthorize any inpatient admission (including inpatient residential, "partial hospitalization" day treatment programs and intensive outpatient care).

Outpatient mental health and substance use disorder treatment does not have to be preauthorized by Care Management. However, if you have your treatment preauthorized by Care Management, you can be assured that your treatment will be considered medically necessary and therefore covered. Care Management has mental health professionals who will help you determine the best course of treatment for you. Your care manager will refer you to an EHP Network provider. If you wish, you may instead refer yourself to any provider in or out of the EHP Network. The choice is yours. However, if you refer yourself to a provider your treatment will only be covered if it is determined to be medically necessary.

You can contact Care Management at 410-424-4476 or 800-261-2429.

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

Note: *You must receive preauthorization by Care Management before all inpatient admissions (including inpatient residential, partial hospitalization day treatment programs and intensive outpatient care) for mental health and substance use disorder treatment. The confidential number to call is 410-424-4476 or 800-261-2429. Failure to obtain preauthorization will result in denial of coverage.*

What's Not Covered by The EHP Classic Plan

The EHP Classic Plan does not cover the following:

- Charges excluded under the **Coordination of Benefits** provisions set forth in the Welfare Benefit Plan Summary Plan Description
- Charges that would not be made if no coverage by the Plan existed
- Charges for which you are not legally required to pay
- Charges in excess of the Allowed Benefit or above the allowable lifetime or annual maximums
- Charges denied by another plan as a penalty for non-compliance with that plan's requirements
- Charges for the completion of claim forms
- Claims filed more than 12 months after the expenses were incurred
- Contraceptive devices, unless required to be covered in comprehensive guidelines supported by the Health Resources and Services Administration and approved by the Food and Drug Administration
- Controlled substances, hallucinogens or narcotics not administered on the advice of a doctor
- Convenience items, such as telephone and television rental, slippers, meals for family members, or first aid kits and supplies
- Copying charges
- Cosmetic/reconstructive surgery. However, cosmetic/reconstructive surgery is covered if needed:
  - because of an accidental injury or illness that is or would be covered by the Plan;
  - because of a congenital malformation of a child;
  - following treatment for morbid obesity, as described earlier in this SPD under ***Obesity Treatment***; or
  - as provided for under ***Women's Health and Cancer Rights Act*** earlier in this SPD
- Custodial care, residential care or rest cures

WHAT'S NOT COVERED

- Dental treatment except in connection with an accidental injury to sound natural teeth that is part of the initial emergency treatment within 48 hours after the accident

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

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

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

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

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

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

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

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

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

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

WHAT'S NOT COVERED

- Glasses, contact lenses, eye refractions, or the examinations for their fitting or prescription, except when medically necessary after cataract surgery or as described under ***Vision Benefits***, earlier in this SPD
- Habilitative services (except for therapy for a person under age 19 with a congenital or genetic birth defect as described under ***Physical, Occupational and Speech Therapy*** earlier in this SPD)
- Hearing aids, or the examination for their fitting or prescription (except for dependent children as described under **Covered Services and Supplies** earlier in this SPD)
- Hypnosis
- Immunizations related to travel unless approved by the Centers for Disease Control guidelines for the countries to be visited
- Injury sustained or an illness contracted while committing a crime, including but not limited to operating a motor vehicle, boat or watercraft while under the influence of alcohol or drugs
- Injury sustained or an illness resulting from war, act of war, act of terrorism, riot, rebellion, civil disobedience, or from military service in any country
- Injury sustained while riding on a motorcycle, unless the covered person was wearing a helmet that meets applicable safety standards issued by the National Highway Traffic Safety Administration. This exclusion applies even when riding in a state that does not require wearing a helmet.
- Marital counseling
- Missed appointment charges
- Myopia or hyperopia correction by means of corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy or laser surgery and all related services
- Nicotine addiction treatment or smoking cessation programs, except as covered by United States Preventive Services Task Force preventive care recommendations with a rating of A or B
- Obesity treatment, including surgical procedures for weight reduction or for treatment of conditions resulting from being overweight, except as described under ***Obesity Treatment*** earlier in this SPD
- Private duty nursing

WHAT'S NOT COVERED

- Private room charges beyond the amount normally charged for a semi-private room, unless a private room is medically necessary
- Recreational therapy and all costs associated with a stay in a recreational, outdoor or wilderness type facility. This exclusion does not apply to medically necessary medical, mental health or substance use disorder treatment received in such facility that would otherwise be covered by this Plan.
- Replacement of braces or prosthetic devices, unless there is sufficient change in the patient's physical condition to make the original brace or device no longer functional
- Reversals of sterilization procedures, such as vasectomies and tubal ligations
- Routine foot care (including any service or supply related to corns, calluses, flat feet, fallen arches, non-surgical care of toenails, and other symptomatic complaints of the feet)
- Self-inflicted injury or illness and expenses resulting therefrom, unless the self-infliction was the result of a mental illness such that application of this exclusion would violate ERISA Section 702
- Services or supplies received before your (or your dependent's) effective date of coverage under the Plan or after the termination date of coverage
- Services and supplies paid in full or in part under any other plan of benefits provided by Johns Hopkins, a school, or a government, or for services you are not required to pay for
- Services and supplies not recommended or approved by a health care professional acting within the scope of their license
- Services and supplies required as a condition of employment
- Services and supplies not specifically listed as covered in this SPD
- Services performed by a doctor or other professional provider enrolled in an education, research, or training program when such services are primarily provided for the purposes of education, research, or training program
- Sexual dysfunction treatment not related to organic disease
- Support garments

WHAT'S NOT COVERED

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

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

- Telephone consultation charges, unless the consultation is medically necessary for treatment of a condition otherwise covered by the Plan

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

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

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

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

- Treatment for which a third party may be liable, unless otherwise payable as described under the Coordination of Benefits provisions set forth in the Welfare Benefit Plan Summary Plan Description

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

- Vision therapy, vision training or eye exercises to increase or enhance visual activity or coordination, and

- Wigs and artificial hair pieces, except in cases of baldness resulting from chemotherapy, radiation therapy or surgery, in which case benefits are limited to one wig once every 24 months, not to exceed $400, as preauthorized by Care Management.

WHAT'S NOT COVERED

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

Administrative Information

Filing A Claim With Employer Health Programs

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

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

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

Itemized bills must include the following information:

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

When the EHP Classic Plan May Recover Payment

If you or your dependents have an injury, illness or other condition that is covered by the EHP Classic Plan and for which a third party might be liable, you must notify Johns Hopkins Employer Health Programs as soon as possible. You must comply with the EHP Classic Plan's Reimbursement and Subrogation rights set forth below as a condition of receiving benefits. Failure to comply is grounds for denial of your claim.

Reimbursement

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

If the Plan has already paid benefits to or on behalf of you or your dependents for treatment of an injury, illness or other condition, you or your dependents (or the legal representatives, estate or heirs of you or your dependents) must promptly reimburse the Plan from any Recovery received for the amount of benefits paid by the Plan. Reimbursement must be made regardless of whether you or your dependents are fully compensated ("made whole") by the Recovery.

In order to secure the Plan's reimbursement rights, by participating in the Plan you and your dependents, to the full extent of the Plan's claim for reimbursement, (1) grant the Plan a first priority lien against the proceeds of any Recovery received; (2) assign to the Plan any benefits you or your dependents may have under any insurance policy or other coverage and (3) agree to hold in trust for the Plan the proceeds of any Recovery received.

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

The Plan is only responsible for those legal costs to which it agrees in writing, and will not otherwise bear the legal costs of you and your dependents. If you take any action to prevent the Plan from enforcing its reimbursement rights, you will also be liable to reimburse the Plan for any legal expenses that the Plan or its agents incur in enforcing the Plan's reimbursement rights.

Subrogation

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

The Plan is subrogated to all of your and your dependents' rights against any party (including an insurance carrier) that is or may be liable for your and your dependents' injury, illness or other condition or for paying for treatment of the injury, illness or other condition. The Plan is subrogated to the extent of the amount of the medical benefits it pays to or on behalf of you or your dependents. The Plan may assert its subrogation right independently of you and your dependents.

You and your dependents are obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested, signing and delivering any documents as the Plan or its agents reasonably request, obtaining the written consent of the Plan or its agents before releasing any party from liability,

taking actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery, and taking no action that may prejudice the Plan's rights.

If you or your dependents enter into litigation or settlement negotiations regarding the obligations of other parties, you and your dependents must not prejudice the Plan's subrogation rights in any way.

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

Benefits Paid by Mistake

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

When You Become Covered By Medicare

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

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

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

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

Medicare and End Stage Renal Disease

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

Non-Discrimination in Benefits

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

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

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

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

Prohibition On Assignment Of Benefits

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

Claims And Appeals

In order for you to receive benefits under the Plan, you or your provider must file a claim. Claims are filed for you by EHP Network providers. An Out-of-Network medical provider can file your claim for you, but if your provider does not file the claim you must file it yourself.

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

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

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

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

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

Certain services and supplies must be preauthorized by Care Management in order to be covered or to avoid a penalty. See the earlier discussion in this SPD about the Care Management Program and the Medical Benefits At-A-Glance chart. If a service or supply must be preauthorized, a request for preauthorization is a "Pre-Service Claim".

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

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

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

If a service or supply does not need to be preauthorized, a claim for payment is a "Post-Service Claim".

Filing a Claim

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

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

JHU
EHP Classic Plan
c/o Johns Hopkins Employer Health Programs
7321 Parkway Drive, Suite 100
Hanover, Maryland 21076

Itemized bills must include the following information:

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

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

Reducing or Terminating an Approved Course of Treatment

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

Extending an Approved Course of Treatment

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

Authorized Representative

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

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

Claims and Appeals Procedures

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

Urgent Care Claims

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

Unless additional information is needed, you will be notified of an Urgent Care Claim decision within 72 hours after the claim is properly filed. However, if your Urgent Care Claim involves a request to

extend an approved course of treatment, and your request is received at least 24 hours before the end of the approved course of treatment, you will be notified of the decision within 24 hours.

Pre-Service Claims

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

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

Post-Service Claims

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

If Additional Information is Needed

Pre-Service and Post-Service Claims

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

Urgent Care Claims

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

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

claim will be processed without the additional information, and Employer Health Programs may draw reasonable presumptions from your failure to supply the additional information.

If Your Claim is Denied

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

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

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

First Level Appeal

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

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

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

Except for an appeal of a denial of an Urgent Care Claim, your First Level Appeal must be in writing. You may hand deliver it to Employer Health Programs or file by mail. If you file by mail, a notice of receipt will be sent to you. The address for First Level Appeals is:

Johns Hopkins HealthCare
Appeals Department
7321 Parkway Drive, Suite 100
Hanover, Maryland 21076

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

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

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

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

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

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

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

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

When Your First Level Appeal Will Be Decided

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

Urgent Care Claim -- You will be notified of the decision within 36 hours after your First Level Appeal is filed.

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

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

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

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

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

Final Appeal

If your First Level Appeal is denied, you may make a Final Appeal to the Plan Administrator. Except for an appeal of a denial of an Urgent Care claim, your Final Appeal must be in writing and must include details about your claim and why you think it should not be denied. You must submit your Final Appeal to the Plan Administrator in care of Johns Hopkins HealthCare Appeals Department at the address shown above.

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

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

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

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

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

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

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

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

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

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

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

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

> **Urgent Care Claim** -- You will be notified of the decision within 36 hours after your Final Appeal is filed.
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> **Pre-Service Claim** -- You will be notified of the decision within 15 days after your Final Appeal is filed.
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> **Post-Service Claim** -- You will be notified of the decision within 30 days after your Final Appeal is filed.
>
> **Reduction or termination of an approved course of treatment** -- You will be notified of the decision within 30 days after your Final Appeal is filed. However, if you filed your final appeal within five days after being notified of the Appeals Department's decision on your First Level Appeal, the approved course of treatment will not be reduced or terminated before your Final Appeal is decided.
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> **Request to extend an approved course of treatment** -- If your Final Appeal is filed before the additional treatment has been provided, the Pre-Service Claim time applies. If your Final Appeal is filed after the additional treatment has been provided, the Post-Service Claim time applies.

You will be sent a written notice of the Plan Administrator's decision. If your Final Appeal is denied, the notice will contain the same type of information as the notice from the Appeals Department. If you disagree with the Plan Administrator's decision, you may bring a civil action against the Plan under ERISA Section 502.

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

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

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

The Plan Administrator may delegate the fiduciary responsibility to decide Final Appeals to an individual person or committee. That person or committee is delegated all power and authority that the Plan Administrator has to decide Final Appeals, including the discretionary authority to interpret the terms of the plan documents and to decide any questions of fact which relate to entitlement to benefits.

External Review

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

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

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

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

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

Request for External Review

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

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

- B. Your appeal relates to a rescission of your coverage (meaning a retroactive cancellation of coverage that was previously in effect), or your claim being appealed involves medical judgment (meaning whether the treatment was medically necessary or experimental).

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

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

Preliminary Review

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

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

Referral to IRO

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

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

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

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

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

Expedited External Review

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

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

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

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

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

Plan Administrator's Authority

The Plan Administrator has discretionary authority to interpret the terms of the EHP Classic Plan as described in this SPD and to decide any questions of fact which relate to entitlement to benefits under the Plan.

For More Information

If you have questions, you can speak with an EHP Customer Service Representative by calling 800-261-2393 or 410-424-4450. Or, contact Office of Benefits Services at 410-516-2000.