THE JOHNS HOPKINS UNIVERSITY LEARNERS' WELFARE PLAN

&

THE JOHNS HOPKINS UNIVERSITY LEARNERS' CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

for House Staff and Salaried Postdoctoral Fellows

Effective July 1, 2023

ABOUT THIS SUMMARY PLAN DESCRIPTION

The following is a summary of some of the principal features of The Johns Hopkins University Learners' Welfare Plan & The Johns Hopkins University Learners' Cafeteria Plan (the "Plan"). This summary, together with the insurance contracts, certificates of coverage, evidence of coverage documents, summary of benefits or other descriptive material listed in Appendix B and provided to you by the insurance companies, service providers, and the Johns Hopkins University Office of Benefits Services (individually and collectively referred to as "Benefits Booklets"), is intended to serve as the Summary Plan Description ("SPD"), as required by the Employee Retirement Income Security Act of 1974 ("ERISA").

We urge you to read this SPD carefully. References to "Plan Sponsor" or "Employer" herein means The Johns Hopkins University and references to the Plan Administrator means The Johns Hopkins University Human Resources Office.

Please also note that this SPD is intended only for House Staff (i.e., residents and interns at the School of Medicine) and Postdoctoral Fellows who receive a wage ("Salaried Postdoctoral Fellows") from The Johns Hopkins University and describes the benefits that are available to these employees.

This SPD is meant to summarize the Plan in easy-to-understand language. Every effort has been made to ensure that this SPD, including the Benefits Booklets, contain a consistent description of the Plan's benefits. However, if there is any conflict or inconsistency between any of these materials, it is the Plan Administrator's responsibility to interpret the conflicting provisions and determine what benefits will be provided under the Plan, and the Plan Administrator has full discretionary authority to do so. If you have any questions about this SPD, Plan benefits or Plan claims procedures, please contact the Plan Administrator.

Please keep in mind that the Plan, any changes to it, or any payments made to you under its terms, does not constitute a contract of employment with the Employer and does not give you the right to be retained in the employment of the Employer. Although The Johns Hopkins University intends to maintain the benefits described in this document for an indefinite period of time, it retains the right to amend or terminate any of the benefits described in this document, as it relates to any employee, dependent, beneficiary or subclass thereof in whole or in part at any time and for any reason in its sole discretion.

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GENERAL INFORMATION ABOUT THE PLAN

Name of Plan

The Johns Hopkins University Learners' Welfare Plan &
The Johns Hopkins University Learners' Cafeteria Plan

Name and Business Address of Plan Sponsor and Employer

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

Plan Sponsor's Taxpayer Identification Number

52-0595110

Name and Business Address of the Plan Administrator

Johns Hopkins University Office of Benefits Services

Plan Number

515

Type of Administration & Funding

The Plan is administered by the Plan Administrator. Please note that participant benefit accounts under the Plan are merely bookkeeping entries. No assets or funds are ever paid to, held in or invested in any separate trust or account, and no interest is paid on or credited to any benefit account. Some benefits may be provided through insurance contracts. To the extent that any benefits are not provided through insurance contracts, they are paid from the Employer's general assets.

Source of Contributions

Employees pay contributions in an amount designated by the Plan Administrator each year, and the Employer will pay the remaining cost of benefits from its general assets.

Discretion of the Plan Administrator

In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's determinations shall be given deference and are final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Plan Year

The Plan Year is the period beginning each July 1 and ending each June 30 while the Plan is in effect. However, the Plan's health care flexible spending account and dependent care flexible spending

account, benefits available to House Staff only, are administered on a calendar year basis, so for purposes of those benefits, Plan Year generally means the calendar year, January 1 through December 31.

Service of Legal Process

Service of legal process may be made upon the Plan Administrator.

Type of Plan

This Plan is a welfare benefit plan providing the following types of ERISA benefits: (a) medical (including prescription drug); (b) dental; (c) vision; (d) life insurance; (e) short and long-term disability; (f) employee assistance program; (g) health care flexible spending account; (h) house staff supplemental fund; and (i) onsite clinics for eligible employees.

Additionally, the Plan also provides a dependent care flexible spending account for House Staff and other dependent care assistance program benefits for House Staff and Salaried Postdoctoral Fellows which are described in this SPD. However, these dependent care benefits are not ERISA plans.

For House Staff, the Plan is also intended to be a "cafeteria plan" within the meaning of Code Section 125. A cafeteria plan allows a portion of the premiums and other costs of health and welfare benefits coverage to be deducted from the salary or wages of House Staff on a pre-tax basis. That is, these contributions should be excludable from the gross income of House Staff for federal income tax purposes (and in most states, state taxes) to the extent permitted by law.

Affordable Care Act

This SPD includes various provisions that are required to comply with the requirements of the federal health care reform law, (the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010) and with regulations and other guidance issued under that law. Whenever this SPD refers to the "Affordable Care Act" it is referring to the PPACA, as amended, and any applicable regulations. The health care reform requirements of the Affordable Care Act generally apply only to the Plan's medical coverage. When this SPD refers to coverage that is subject to the Affordable Care Act, it means the Plan's medical coverage. Generally, these PPACA requirements include the following:

- *No Lifetime or Annual Limits*. The Plan will not impose a lifetime or annual limit on the dollar value of Essential Health Benefits provided under the Plan.
  - "Essential Health Benefits" are health-related items and services that fall into the following categories, and further determined by the Secretary of Health and Human Services:
    - Ambulatory patient services;
    - Emergency services;
    - Hospitalization;
    - Maternity and newborn care;
    - Mental health and substance use disorder services, including behavioral health treatment;
    - Prescription drugs;
    - Rehabilitative and habilitative services and devices;
    - Laboratory services;
    - Preventive and wellness services and chronic disease management; and

        - Pediatric services, including oral and vision care.

    - For purposes of determining whether a benefit or service under the Plan is an Essential Health Benefit, the Plan has chosen the state of Utah as its benchmark state.

- *No Rescission of Coverage*. The Plan will not cancel or discontinue medical benefits under the Plan with a retroactive effect with respect to you or your covered dependents, except in the event of fraud, intentional misrepresentation, nonpayment of premiums, etc. In the case of a permitted retroactive rescission, the Plan will provide at least 30 days' advance written notice to any person who will be affected by the retroactive termination of coverage.

- *No Cost Sharing on Recommended Preventive Care*. The Plan will not require participant cost-sharing on recommended preventive care provided by in-network providers. Preventive care services covered in-network at 100% will be reviewed annually and updated prospectively to comply with recommendations of:

    - the United States Preventive Care Task Force;
    - the Advisory Committee on Immunization Practices that have been Adopted by the Director of the Centers for Disease Control and Prevention; and
    - the Comprehensive Guidelines Supported by the Health Resources and Services Administration.

- *No Preexisting Condition Exclusions*. The Plan will not impose a pre-existing condition exclusion on medical benefits.

- *Coverage of Clinical Trials*. Medical benefits under the Plan will not deny participation in an approved clinical trial for which a participant or dependent is a qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. A participant or dependent participating in such an approved clinical trial will not be discriminated against on the basis of their participation in the approved clinical trial.

- *Cost Sharing*. Medical benefits under the Plan will comply with the overall cost-sharing limit (i.e., out-of-pocket maximum) mandated by the Affordable Care Act, indexed annually. For purposes of this provision, cost-sharing includes deductibles, co-insurance, co-payments or similar charges, and any other required expenditure that is a qualified medical expense with respect to Essential Health Benefits covered under the Plan. Cost-sharing shall not include premiums, balance billing amounts for non-network providers or spending for services that are not covered under the Plan.

- *Medical Loss Ratio*. With respect to any insurance company rebate received by the Plan Sponsor (if any), that are subject to the Medical Loss Ratio provisions of the Affordable Care Act, the Plan Sponsor will determine what portion (if any) of such rebate must be treated as plan assets under ERISA. If any portion of the rebate must be treated as plan assets, the Plan Sponsor will determine in its sole discretion the manner in which such amounts will be used by the Plan or applied to the benefit of participants, which participants need not be the same participants who made contributions under the policy that issued the rebate. Any portion of the rebate that is not treated as plan assets will be allocated to the Employer as the Plan Sponsor, in its sole discretion, determines appropriate.

ELIGIBILITY

Employee Eligibility

If you are an employee on the payroll of the Employer who is classified by the Employer as House Staff or a Postdoctoral Fellow receiving a wage from the Employer (i.e., a "Salaried Postdoctoral Fellow"), then you and your eligible dependents are eligible to participate in the Plan beginning on the date you become an eligible employee of the Employer (your "Participation Date"). House Staff generally become eligible employees on the effective date of their appointment with the Employer.

The following persons are not permitted to participate in the Plan: any person who is (a) a medical student, graduate school student, (b) a Postdoctoral Fellow who does not receive a wage from the Employer or who is paid through a stipend, (c) trainee, visiting student, or special student, (d) any other type of person who does not receive a wage from the Employer, or (e) a leased employee, person classified by the Employer as temporary employees (as determined by the Employer), employees covered by a collective bargaining agreement and their dependents (unless Plan participation is provided for in the collective bargaining agreement).[1] A person who is not characterized by the Employer as an employee of the Employer, but who is later characterized by a regulatory agency or court as being an employee, will not be eligible for the period during which he or she is not characterized as an employee by the Employer and will be eligible prospectively from the later of the actual or the effective date of the reclassification and only if all other eligibility requirements are met.

If your employment terminates while you are a participant in the Plan (or if you cease to be an eligible employee for any other reason) and you later become an eligible employee again, you will again become a participant in the Plan beginning on the date you become an eligible employee. However, if you are rehired (or again become an eligible employee for any other reason) during the same Plan Year and within 30 days after your previous period of eligible employment ended, you generally will not be permitted to make a new election of benefits for that Plan Year, but your previous election of benefits will be reinstated.

Please note that your eligibility for any particular benefit is determined under Plan terms, including the Benefit Booklet(s) applicable to that benefit. In addition, the Benefits Booklets delivered with this SPD (see Appendix A) include information about any additional or different eligibility requirements that may apply to specific benefits.

Dependent Eligibility

(NOTE: This Dependent Eligibility section does not apply to flexible spending account benefits. For details on whether a family member's expenses can be covered under a flexible spending account, see the separate explanations of those benefits in the "Summary of Available Benefits" section.)

For purposes of benefits offered under the Plan that allow you to enroll dependents, your *spouse* or *domestic partner* is considered an eligible dependent (*spouse*, *domestic partner* and other *italicized* terms used in this section are defined below).

Your *child* is eligible for coverage offered to dependents under the Plan based on the following rules:

[1] While medical students, graduate school students, postdoctoral fellows who do not receive a wage, trainees, visiting students or special students may be eligible for some of the same benefits as House Staff and salaried Postdoctoral Fellows, as may be amended from time to time by the Employer, these individuals are not eligible to participate in this Plan.

1. <u>Coverage for Children under Age 26</u>. Your eligible dependents include your *child* who is under age 26, regardless of the child's marital status, tax dependent status or student status and regardless of whether the child lives with you.

2. <u>Coverage for Children with Disabilities</u>. For purposes of all coverage offered to dependents under the Plan, your unmarried *child* who is your *dependent for federal income tax purposes* for the applicable calendar year is an eligible dependent if he or she is physically or mentally incapable of self-support, but only if the physical or mental incapacity commenced before the child reached age 26. You must submit written proof of your child's incapacity within 30 days after the child reaches age 26, or, if later, upon enrollment in the Plan which shall include verification that the incapacity started prior to age 26.

   The following definitions apply for purposes of this Dependent Eligibility section:

   - *Child* means a natural child, a legally adopted child, a child placed with you for adoption, a foster child (if the child is an "eligible foster child," as defined in the Internal Revenue Code), a stepchild or a child of your domestic partner. *Child* also includes any other person for whom you are acting as a parent if their welfare is your legal responsibility under a legal guardianship, written divorce settlement, written separation agreement or a court order.

   - *Spouse* means your legal spouse under federal law (1 USC § 7).

   - *Domestic partner* means someone who qualifies as your domestic partner under the Employer's domestic partner policy and only after the domestic partnership has been declared on a form and manner required by the Plan Administrator. For more information about that policy, please contact the Plan Administrator.

<u>Tax Consequences of Domestic Partner and Domestic Partner Children's Benefits</u>

Unless your domestic partner or their dependent children, if any, are considered your federal tax dependents under the Internal Revenue Code for health benefit purposes as described below, the Internal Revenue Service currently treats as imputed income to you the value of the coverage provided for your domestic partner and their dependent children, if any, less any contributions paid by you on an after-tax basis for this coverage. In general, a domestic partner (or their child) who is a member of your household qualifies as your tax dependent for health benefit purposes if:

- He or she receives more than 50% of their financial support from you;
- He or she lives with you (shares a personal residence) for the full tax year (except for temporary reasons such as vacation, military service or education);
- He or she is a citizen, national or legal resident of the United States; or a resident of Canada or Mexico; or is a child being adopted by a US citizen or national;
- He or she is not a section 152 qualifying child dependent on another taxpayer's filed return or is a section 152 qualifying child dependent on another taxpayer's return where the filing is only to obtain a refund of withheld income taxes; and
- Your relationship is not in violation of any local laws.

You are advised to consult with your tax advisor to determine if your domestic partner or their dependent children are your federal tax dependents and to review the federal and state tax consequences of

covering your domestic partner and/or their children under the Plan. You will be asked to certify whether your domestic partner and their children qualify as federal tax dependents upon enrollment in the Plan and at various other times as determined by the Plan Administrator.

A person otherwise qualifying as your eligible dependent will not be covered for any coverage providing benefits to dependents unless you have elected to pay and have paid the required additional contributions, if any, for dependent coverage. Also, unless otherwise required by law, note that your spouse or domestic partner will not qualify as an eligible dependent while on active duty in the armed forces of any country.

You are responsible for determining if someone qualifies as your spouse or dependent for purposes of the Plan's dependent eligibility rules, subject to the Employer's final approval. The Employer may require you to provide proof that an individual satisfies all of the Plan's eligibility requirements. Also, if at any time during a Plan Year your eligible spouse or dependent becomes ineligible for coverage, you are responsible for notifying the Employer of that change in eligibility. If, at any time, the Plan pays benefits for any person you elected to enroll in your coverage who is later determined not to qualify as your eligible dependent, the Plan may recover from you any amounts paid for such benefits, using any recovery means available under applicable law (including, but not limited to, wage garnishment). Additionally, the inclusion of an ineligible dependent or the failure to remove an ineligible dependent is considered fraud on the Plan and your coverage may be terminated retroactively in compliance with the Affordable Care Act.

For purposes of the Plan's medical, dental or vision coverage, if a child would otherwise qualify as a dependent of more than one participant, the child may be treated as the dependent of only one participant.

Please note that for any insured coverage offered under the Plan, the terms of the insurance contract, instead of this "Dependent Eligibility" section, will determine whether any person is your dependent for purposes of that benefit (if there is any difference between the language in this Dependent Eligibility section and the terms of the contract). The Benefits Booklets provided to you with this SPD will include any additional or different dependent eligibility requirements that apply for any insured coverage.

All Qualified Medical Child Support Orders that provide Plan coverage for so-called "Alternate Recipients" will be honored by the Plan. (These orders are a type of order by a court or by an administrative agency providing coverage for children of Plan participants.) As required by applicable law, the Plan uses procedures to determine whether a medical child support order is a "Qualified Medical Child Support Order" that must be honored by the Plan. Upon request to the Plan Administrator, you may receive, without any charge, a summary of these procedures.

ELECTIONS AND PARTICIPATION

Elections and Changes to Elections

(a) Initial Election Period. If you are not already a participant in the Plan, to become a participant on your Participation Date, you must be an active employee of the Employer on your Participation Date and you must properly complete and submit any required initial application or form ("Election Form") to the Plan Administrator (or complete a designated electronic enrollment process, if available) during the period designated by the Plan Administrator as your initial "enrollment period," which shall end no more than 30 days after your hire or appointment date. If you are a new employee and your Participation Date is the date you became an employee or were appointed, you may complete and submit your Election Form (or complete a designated electronic enrollment process, if available) during your first thirty days of employment or appointment and your coverage will be effective retroactive to your Participation Date (the date you were

hired or appointed). However, if you miss the initial enrollment period of 30 days, but enroll within 60 days after your hire or appointment date, you will be enrolled only on a prospective basis. Note that you will not be considered a new employee for purposes of this rule if you are a rehired employee and you were rehired within 30 days after your employment with the Employer terminated or if you are returning to work following an unpaid leave of absence of less than 30 days.

Your benefit elections made during your initial enrollment period will be effective from your Participation Date until the last day of the Plan Year in which you change your initial benefit election (see subsection (b) below) or until you experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (f) below) or qualify to change your elections for certain other reasons (see subsections (d) and (e) below).

If you fail to properly complete and submit any applicable Election Form to the Plan Administrator during your initial election period, you will automatically receive applicable Employer-paid life insurance, long term disability, and self-only medical, dental, vision and employee assistance program coverage (if you are eligible for these Benefits), but you will not automatically participate in any other feature of the Plan.

(b) Election Periods after Initial Election Period. After you complete the initial Election Form, your initial benefit election (or the equivalent as determined by the Plan Administrator in its sole discretion) will remain in effect indefinitely (i.e., will carry over each Plan Year) or until you experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (f) below) or qualify to change your elections for certain other reasons (as described in subsections (d) and (e) below) or until you make a new benefit election by requesting, completing and submitting a new Election Form to the Plan Administrator during the period preceding the Plan Year that is designated by the Plan Administrator as the annual "open enrollment period." Your new benefit election will be effective from the first day of the Plan Year following the election period in which you make your new benefit election until you change your election during a later election period, experience a Status Change, exercise a Special Enrollment right or otherwise qualify to make an election change that is permitted under the Plan. For House Staff employees, this automatic carry-over of previous elections does not apply to elections regarding participation in the Plan's health care flexible spending account or dependent care flexible spending account; failure to complete and submit a new Election Form means House Staff employees will not automatically receive coverage under these flexible spending accounts.

Although your benefit elections normally will carry over from one Plan Year to the next as described above, the Employer may announce before the start of a Plan Year that new elections will be required for all eligible employees to participate in benefits for that upcoming Plan Year. In such cases, a special required election period will be announced for all eligible employees to make new elections, which will take effect at the beginning of the next Plan Year. An employee who fails to make an election of available benefits during the special required election period will cease to participate in the Plan (except for purposes of any Employer-paid benefits that may be provided automatically without the need for an election, as described in subsection (a) above) at the end of the Plan Year in which the special required election period occurs.

(c) Changes of Election to Reflect Status Change. If you are currently participating in the Plan, you may, with the approval of the Plan Administrator and subject to the requirements described below and any conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, change your elections by filing a Status Change Form within 30 days after a Status Change event. If you are not currently a participant in the Plan but you have satisfied all the requirements to be eligible to participate (except that you do not have a current benefit election in place), with the approval of the Plan

Administrator and subject to the requirements described below and any conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, you may become a participant by filing an Election Form and a Status Change Form within 30 days after a Status Change event occurs.

Under applicable law, to be permitted to make a change in your benefit elections because of a Status Change event, the Status Change event must result in you or your spouse or dependent gaining or losing eligibility for that coverage or similar coverage under the Plan, a plan sponsored by another employer by whom you are employed or a plan sponsored by the employer of your spouse or other dependent. (For dependent care flexible spending account benefits, House Staff are also permitted to make an election change if a Status Change increases or decreases your eligible dependent care expenses and the election change corresponds to the change in expenses.)

Any change that you wish to make to your benefit elections also must be consistent with the Status Change event that occurred. The Employer will determine whether, under applicable law, a requested change (or a new election) is consistent with the Status Change you experience. For example, if you become eligible for health coverage offered by your spouse's employer because you get married or because your spouse changes employers, you may cancel your health coverage under this Plan only if you certify to the Employer that you have actually enrolled or intend to enroll in the other Plan. Under applicable law, it would not be consistent with the Status Change if you merely dropped coverage under this Plan without enrolling in the other plan.

Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the elections are approved by the Plan Administrator, and will be effective, for health care flexible spending account or dependent care flexible spending account coverage, for the balance of the Plan Year in which the new election is made or, for all other coverage, until you change your elections according to the Section entitled "Election Periods After Initial Election Period" or you experience another Status Change.

You will experience a Status Change if:

(1) your legal marital status changes including changes because of marriage, the death of your spouse, divorce, legal separation or legal annulment;

(2) there is an event that causes you to gain or lose a dependent;

(3) you, your spouse or your dependent terminates or begins employment;

(4) there is an increase or reduction in hours of employment (including a switch between part-time and full-time employment, a strike or lockout, or the beginning or ending of an unpaid leave of absence) by you or your spouse or other dependent;

(5) you, your spouse or your dependent becomes eligible or loses eligibility for coverage under a plan offered by that person's employer because of a change in employment status (for example, if your dependent switches from hourly to salaried employment and the dependent's employer's medical plan covers only salaried employees);

(6) an event happens that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or similar circumstance;

(7) there is a change in location of the residence or worksite of you or your spouse or

other dependent;

(8) for purposes of dependent care flexible spending account benefits, there is an event that changes the number of your dependents who are under the age of 13 or mentally or physically incapacitated;

(9) for any election made on an after-tax basis, you experience any event which, in the Administrator's sole discretion, qualifies as a Status Change; or

(10) you enroll in coverage through a government-sponsored health insurance marketplace during a special or annual enrollment period as long as you certify to the Plan Administrator that you and any covered dependents have obtained minimum essential coverage on the health insurance marketplace immediately upon the cancellation of coverage under this Plan.

(d) Changes of Election Because of Changes in Cost or Coverage. You may make certain changes, as described below, because of changes in cost or coverage of benefits available under the Plan. You must request such an election change within 30 days after your right to change your election arises (as determined by the Plan Administrator, in its discretion). Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the Election Form, if required, and the elections are approved by the Plan Administrator, and will be effective, for dependent care flexible spending account coverage, for the balance of the Plan Year in which the new election is made or, for all other coverage, until you change your elections according to the Section entitled "Election Periods After Initial Election Period".

The rights described in paragraphs (i)-(iv) below are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan. Also, the rights described in (i)-(iv) below do not apply to elections involving a health care flexible spending account. You may not change the amount you contribute to a health care flexible spending account because of a change in cost or a change in coverage of another benefit option and you may not make an election change for any other benefit option because of a change in the cost or coverage under your health care flexible spending account or the health care flexible spending account of your spouse or dependent.

(i) Significant Cost Changes. If the amount that you are required to pay for a benefit option significantly increases (as determined by the Employer) while you are covered under that benefit, you may elect to revoke your election for that benefit and elect another similar benefit option, if one is available (as determined by the Employer). If no similar benefit option is available, you may elect to drop your coverage because of the increased cost.

If the amount that you are required to pay for a benefit option significantly decreases (as determined by the Employer) during the Plan Year, you may elect that benefit option for yourself or an eligible spouse or dependent.

Ordinarily, you may change the amount you contribute to a dependent care flexible spending account because of a significant increase or decrease in cost. However, under applicable law, if the dependent care provider who is imposing the increased cost is a close relative of yours, you cannot change your election. For this purpose, a close relative includes your parent, grandparent, child, grandchild, brother, sister, niece, nephew, stepparent, stepchild, stepbrother, stepsister, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law or brother-in-law.

You may change your elections because of a significant cost change, as described

above, regardless of the reason for the increase or decrease in your cost. It does not matter whether the change in cost results from an action taken by the Employer or if it occurs because of something you do (such as switching from part-time to full-time employment if that changes the amount you have to pay for coverage).

(ii) Significant Coverage Changes.

(A) Significant Curtailment Without a Loss of Coverage. If your coverage under a benefit is significantly curtailed during the Plan Year, you may revoke your election of that benefit and elect another benefit option that offers similar coverage (as determined by the Employer), if any. Coverage is significantly curtailed only if there is an overall reduction of the coverage provided to all participants (as determined by the Employer).

(B) Significant Curtailment With Loss of Coverage. If your coverage under a benefit is significantly curtailed during the Plan Year (as determined by the Employer), and the significant curtailment amounts to a complete loss of coverage (as determined by the Employer), you may change your elections as described in the previous paragraph. In addition, if you experience a complete loss of coverage and no other benefit option that provides similar coverage is available, you may drop the coverage entirely. A loss of coverage includes, for example, the elimination of a benefit option, the loss of availability of an HMO option in the area where you or your dependent reside, or a loss of coverage for you or a dependent under a health plan option because your expenses exceed an annual limit. The Employer, in its discretion, will determine when a curtailment of a benefit amounts to a complete loss of coverage.

(C) Additional of or Improvement of Benefit Option. If the Employer adds a new benefit option or if an existing benefit option is significantly improved during a Plan Year (as determined by the Employer), you may change your elections to replace a benefit option that provides similar benefits with the new or improved benefit option, or, if you did not previously elect a similar benefit option, you may elect to begin participating in the new or improved benefit option.

(iii) Changes in Coverage of Dependents Under Other Plans. You may also change your elections to correspond to certain changes made under another employee benefit plan. For example, if your spouse's employer has a cafeteria plan with an election period that is different from this Plan's open enrollment period, you may change your benefit elections to correspond to the changes elected by your spouse during their employer's open enrollment period. Also, if another employer sponsors a cafeteria plan that allows participants to make changes during a Plan Year, such as the ones permitted by this Plan, and a permitted change under that other plan affects you or your eligible dependent, you may elect changes to your coverage under this Plan, as long as your change corresponds with the change made under that other plan. For example, if your spouse revokes a benefit election for a medical plan offered by their employer because of an increase in cost, you could change your elections under this this Plan to elect coverage for your spouse.

(iv) Loss of Other Group Health Coverage. If you or your eligible spouse or dependent loses coverage for any group health coverage sponsored by a governmental entity or an educational institution (as determined by the Employer), you may change your election of benefits to elect coverage for the affected individual.

(e) Other Election Changes. Except as otherwise provided below, if you are entitled to an election change described below, you must request the change within 30 days after your right to change your election arises (as determined by the Plan Administrator, in its discretion).

(i) Orders Requiring Coverage. If you are subject to a judgment, decree or order resulting from a divorce or similar proceeding that requires you to provide medical coverage for your child (including a "qualified medical child support order" defined in ERISA Section 609), subject to the Employer's approval, the Plan Administrator may change your health coverage election if the Plan is required by the order to provide such coverage and may change the amount of your salary reduction contributions to cover the cost of such coverage. If your former spouse or another individual is required to provide coverage for your child pursuant to such a judgment, decree or order and you provide evidence to the Employer that such coverage is actually being provided, subject to the Employer's approval, you will be permitted to change your election to stop providing medical coverage for your child.

(ii) Medicare or Medicaid Enrollment. If you or your spouse or dependent becomes enrolled in Medicare or Medicaid, subject to the Employer's approval, you may change your election to cancel or reduce medical coverage for that individual. If you or your spouse or dependent loses eligibility for Medicare or Medicaid, again subject to the Employer's approval, you may change your election to commence or increase medical coverage for that individual.

(v) FMLA Leave. If you take leave under the Family and Medical Leave Act of 1993 (FMLA), you may make certain election changes that are permitted by the Employer in accordance with the FMLA.

(f) Special Enrollment Periods for Employees and Dependents. If you decline enrollment in the Plan's medical coverage options for yourself or your dependents (including your spouse or Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's medical coverage if you or your dependents lose eligibility for that other coverage (or if an employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, you may be able to enroll yourself and your dependents in the Plan's medical coverage. However, you must request enrollment within 30 days after the marriage. If you have a new dependent as a result of birth, adoption, or placement for adoption, you may request enrollment up to 90 days after the birth, adoption or placement for adoption.

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

If you are eligible to make a special enrollment election described in this section, you may elect coverage under any medical coverage options for which you are eligible under the Plan. If you are eligible for more than one medical coverage option and you are currently enrolled in one coverage option, you may change to a different medical coverage option that is available to you. Benefits elected during a special enrollment period become effective no later than the first day of the first month that starts after you properly elect coverage. However, for a special enrollment election based on a birth, adoption or placement for adoption, your coverage would be effective starting on the date of the birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator at the address provided in this SPD.

Termination of Participation

Coverage for a *participant* generally terminates on the earliest of the following dates:

(a) The last day of the month in which the participant terminates employment.

(b) Except for certain leaves of absence, the last day of the month in which the participant ceases to qualify as an eligible employee of the Employer or a participant.

(c) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid or, if later and if contributions are discontinued because the participant is no longer an eligible employee, the last day of the month in which the participant ceases to qualify as an eligible employee.

(d) Except to the extent required by law, the day on which the participant reports for active duty as a member of the armed forces of any country.

(e) The day on which all benefits, or the applicable benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by the Employer.

Coverage for an *eligible dependent* of a participant generally terminates at the same time that coverage for a Participant terminates or, if earlier, on the earliest of the following dates:

(a) The last day of the month in which the participate terminates employment

(b) The last day of the month in which the participant ceases to qualify as an eligible Employee of the Employer or a participant.

(c) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid.

(d) Except to the extent required by law, the day on which the eligible dependent reports for active duty as a member of the armed forces of any country.

(e) The day on which all benefits, or the applicable benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by the Employer.

(f) The last day of the month in which the eligible dependent ceases to qualify as an eligible dependent for any reason other than a dependent who is covered as child of a participant and reaches age 26. In that case, coverage for an eligible dependent who is covered as a child of a participant will terminate at the end of the calendar year in which the defendant reaches age 26.

Coverage under the Plan may also be retroactively terminated for any individual (or any employee or dependent covered under the same family coverage as that individual) who engages in fraud or who makes a material misrepresentation of fact relating to the coverage. For example, if someone knowingly files a claim for benefits for medical services or supplies that were not actually provided, that would be considered fraud and would lead to termination of coverage. An example of a material misrepresentation

of fact would include an employee signing an enrollment form indicating that an individual is eligible for coverage as a dependent at a time when the employee knows that the individual does not qualify as the employee's dependent. In such cases, coverage may be terminated retroactively in accordance with the Affordable Care Act, as described above in the "*General Information About the Plan*" section.

If your coverage terminates under certain conditions, you may have the right to elect continuation coverage for certain benefits offered under the Plan. See the "Continuation and Conversion Rights" and "COBRA Notice" sections of this SPD for more details.

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

If you are on an approved leave of absence, your coverage will not terminate because of the leave of absence as long as you pay your share of any required contributions, if any, on time (in the manner and timeframe specified by the Employer on commencement of your leave of absence). If you do not return to work when your leave of absence ends or if you fail to pay any required contributions on time, coverage will be terminated, subject to any COBRA rights or any other provision of this Plan that may provide for continued coverage. Continuation under this provision is dependent upon your compliance with all reasonable requests for documentation of your status.

BENEFITS

Summary of Benefits Available to House Staff and Salaried Postdoctoral Fellows:

The following benefits are presently available under the Plan. Please note that all elections and benefits under the Plan are subject to change and to a number of legal rules. If any of these rules require a change to your elections or benefits, you will be notified.

- **Medical and Prescription Drug Coverage.**

House Staff and Salaried Postdoctoral Fellows are eligible to participate in a medical and prescription drug benefit plan option sponsored and self-funded by The Johns Hopkins University and administered by The Wellfleet Group, LLC. House Staff eligible to participate in the Plan may elect to receive at the Employer's sole expense medical and prescription drug coverage for themselves and any eligible dependents. Salaried Postdoctoral Fellows eligible to participate in the Plan may also elect to receive medical and prescription drug coverage for themselves and any eligible dependents; however, the portion of contributions Salaried

Postdoctoral Fellows will be responsible for will be determined by the respective department. If you have medical coverage under another plan, such as a plan sponsored by your spouse's or domestic partner's employer, and you prove you have such coverage as required by the Plan Administrator, you may waive coverage under the Plan.

A detailed description of the medical and prescription drug coverage benefits appears in the Benefits Booklet.

- **Dental Coverage.**

House Staff eligible to participate in the Plan will automatically receive at the Employer's sole expense self-only dental coverage fully insured by Delta Dental. House Staff may elect to receive dental coverage for any eligible dependents also by filing the appropriate Election Form.

Salaried Postdoctoral Fellows eligible to participate in the Plan will automatically receive at the Employer's sole expense self-only dental coverage fully insured by Delta Dental. Salaried Postdoctoral Fellows may also to receive dental coverage for any eligible dependents also by filing the appropriate Election Form; however, the portion of premium payments Salaried Postdoctoral Fellows will be responsible for will be determined by the respective department. A detailed description of this coverage appears in the Benefits Booklets (see Appendix A).

- **Vision Coverage.**

If you are eligible to participate in the Plan, you will automatically receive at the Employer's sole expense self-only vision coverage fully insured by EyeMed.

House Staff and Salaried Postdoctoral Fellows enrolled at School of Medicine, School of Nursing, School of Public Health, and Berman Institute of Bioethics will receive at the Employer's sole expense one annual comprehensive eye examination/contact lens evaluation provided by the Wilmer Comprehensive Eye Care. The Wilmer Comprehensive Eye Exam is not available for any dependents. A detailed description of these coverages appear in the Benefits Booklets.

- **Life Insurance Coverage.**

If you are eligible to participate in the Plan, you will receive at the Employer's sole expense employee-only life insurance coverage insured by UNUM. A detailed description of this coverage appears in the Benefits Booklets.

- **Short-Term Disability Coverage.**
  Salaried Postdoctoral Fellows enrolled in KSAS, WSE, CBS, BSPH, SAIS and SOE only

Salaried Postdoctoral Fellows enrolled only in the Krieger School of Arts and Sciences, Whiting School of Engineering, Carey Business School, Bloomberg School of Public Health, School of Advanced International Studies, and School of Education will automatically receive at the Employer's sole expense short-term disability coverage offered through Lincoln Financial Group.

House Staff and Salaried Postdoctoral Fellows enrolled in the School of Medicine, School of Nursing and Peabody Institute, are not eligible for short-term disability coverage offered through Lincoln Financial Group. For information about short-term disability coverage available to House Staff and Salaried

Postdoctoral Fellows enrolled at the School of Medicine, see the "Health Care and Sick Leave Policy" below.

Below is a summary. A detailed description of this coverage appears in the Benefits Booklets.

How Short-Term Disability Benefits Work

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

For the purposes of the short-term disability benefit plan, you are "disabled" if the insurer Lincoln Financial Group determines that:

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

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

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

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

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

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

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

Filing Claim for Benefits

You should apply for short term disability benefits as soon as you are aware that your absence will extend beyond 14 days. You apply by calling Lincoln Financial Group at 888-246-4483 to begin the claim process. When you apply, you will need to provide proof of your disability. See the Benefits Booklet for more details. If proof of your disability is not provided within 30 days, your short-term disability benefits may be suspended or terminated. On a periodic basis, you may be asked to submit proof of your ongoing disability to Lincoln Financial Group. You are responsible for the cost of providing this information. In addition, Lincoln Financial Group has the right to have you examined, at its expense, as often as necessary while your disability claim continues.

- **Health Care and Sick Leave Policy**
  House Staff and Salaried Postdoctoral Fellows enrolled in SOM only

House Staff and salaried postdoctoral fellows at the School of Medicine are eligible for certain health care and sick leave benefits for their own or a family member's illness or injury, as described in the School of Medicine's Health Care and Sick Leave Policy, Postdoctoral Trainees and available here: https://hpo.johnshopkins.edu/doc/fetch.cfm/8PuUU0s8

- **Long-Term Disability Coverage.**

If you are eligible to participate in the Plan, you will receive at the Employer's sole expense employee-only long-term disability coverage fully insured by UNUM.

Below is a summary. A detailed description of this coverage appears in the Benefits Booklets.

How Long-Term Disability Coverage Works
If you are disabled as determined by UNUM and are unable to work due to an illness or injury, long-term disability benefits generally pay 60% of your pre-disability monthly earnings to a monthly maximum benefit of $10,000. You are not considered disabled if you are able to earn 80% of your pre-disability income.

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

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

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

- Social Security;
- Workers compensation;
- Any payments under an occupational disease act or law;
- Any occupational accident coverage;
- A state teachers retirement system;
- Benefits under a statutory disability benefit law;
- The Railroad Retirement Act;
- The Canada Pension Plan, Québec Pension Plan, or Canada Old Age Security Act; or
- Any other public employee retirement system plan.

If benefits under certain programs listed above increase while you are receiving LTD benefits, your LTD benefit may not be further reduced based on that increase. If you expect to become eligible for Social Security disability benefits, it is assumed that you will apply. Service representatives from Lincoln Financial Group are available to assist you in applying for and securing a Social Security disability award, at no charge to you. The maximum payment period of LTD benefits depends on your age when you became disabled, as detailed in the Benefits Booklets. Benefits will end earlier if you cease to be totally disabled or you fail to comply with any requirements to provide proof of your ongoing disability.

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

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

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

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

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

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

Filing Claim for Benefits
Unum is the Network/Claim Administrator for the Long-Term Disability coverage. To file a claim for benefits, follow the procedures in the certificate of coverage, available here: https://myahpcare.com/wp-content/uploads/JHU-Medical-MD-Long-Term-Disability-Policy.pdf.

Features that apply to BOTH Short-Term and Long-Term Disability Plans

Exclusions

Short-term and long-term disability coverage does not cover any loss caused by, contributed to or resulting from:

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

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

When Your Disability Coverage Ends
Your disability coverage will end on the earliest of:

- The date the plan is terminated; or
- The date you retire or otherwise terminate employment with JHU.

If you cease work due to leave of absence or military leave, coverage will continue for three months after the date you last actively worked.

- **Employee Assistance Program.**

If you are eligible to participate in the Plan, you will automatically receive at the Employer's sole expense an employee assistance program for both you and your eligible dependents. A detailed description of this coverage appears in the Benefits Booklets.

- **Onsite Health Clinics.**
  Eligibility Varies; Read Closely

If you are eligible to participate in the Plan, you will automatically have access to one of three onsite health clinics depending on which division you are affiliated with.

The Student Health and Wellness Center – Salaried Postdoctoral Fellows enrolled in the Krieger School of Arts and Sciences, Whiting School of Engineering, School of Education, and Sheridan Libraries are eligible to receive certain medical services at the Student Health and Wellness Center. The Student Health and Wellness Center is located at 1 E. 31st Street., N200, at the corner of 31st and Charles Street and offers a broad range of primary care services including illness and injury, routine gynecologic care, travel consultation, allergy injections, immunizations, and many others. A detailed description of the Student Health and Wellness Center's services is available at https://studentaffairs.jhu.edu/student-health/.

University Health Services (UHS) – House Staff and Salaried Postdoctoral Fellows enrolled in the School of Medicine, School of Public Health, School of Nursing, and the Berman Institute of Ethics are eligible to receive certain medical services at the University Health Services clinic. UHS is located at 933 N Wolfe St, Baltimore, MD 21205 and offers primary care services, including the evaluation and treatment of most acute and/or chronic medical conditions affecting adults as well as routine gynecological examinations including pap smears. A detailed description of UHS is available at https://studentaffairs.jhu.edu/university-health-services/.

- **Dependent Care Voucher Program.**

If you are eligible to participate in the Plan, you are eligible to participate in the Dependent Care Voucher Program which is a childcare benefit offered by the Employer, as such program is set forth and amended

from time to time at https://hr.jhu.edu/benefits-worklife/family-programs/child-care/2020-dependent-care-voucher/. Dependent Care Voucher Program is not subject to the federal law known as ERISA, so the "Your Rights under ERISA" section of this SPD does not apply to these benefits.

- **Backup Childcare Program.**

If you are eligible to participate in the Plan, you are eligible to participate in the Backup Childcare Program which is a childcare benefit offered by the Employer, as such program is set forth and amended from time to time at https://hr.jhu.edu/benefits-worklife/family-programs/child-care/backup-care/. Backup Childcare Program is not subject to the federal law known as ERISA, so the "Your Rights under ERISA" section of this SPD does not apply to these benefits.

Summary of Additional Benefits Available to House Staff Only:

This section describes three categories of benefits available to House Staff only: House Staff Supplemental Fund, the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account.

House Staff Supplemental Fund. House Staff eligible to participate in the Plan and participate in the Plan's medical coverage will receive at the Employer's sole expense a cash reimbursement for certain health-related expenses that qualifies as a health reimbursement arrangement in accordance with IRS Notice 2002-45. This fund is not considered to be part of the Cafeteria Plan or subject to Code Section 125. A detailed description of this coverage appears in the Benefits Booklets (see Appendix A) delivered to you with this SPD.

Health Care Flexible Spending Account (Health Care FSA). Except as is provided below, House Staff eligible to participate in the Plan may elect to have salary reduction contributions, in an aggregate amount not to exceed $3,050 (as adjusted for inflation pursuant to Code Section 125(i)) per Plan Year, credited to a Health Care FSA.

Reimbursements from Health Care FSA: Amounts from a Health Care FSA account are for reimbursement for eligible medical expenses (as defined in the Plan) incurred during the Plan Year and while you are a participant in the Health Care FSA. Generally, eligible medical expenses are expenses that you or your dependent (determined as described below) have incurred that are not covered under any plan or employer-provided medical coverage, that meet the Internal Revenue Code's definition of medical expenses (including legally obtained prescription drugs or insulin), and that have not been taken as a deduction in any year. As required by law, the Health Care FSA does not reimburse expenses for over-the-counter medicine (other than insulin), unless the medicine has been prescribed by a physician or another qualified health care provider. Normally, expenses are reimbursable only if you have already incurred the expense (that is, if you have already received the services or medicine or supplies to which the expense applies). However, otherwise eligible expenses for orthodontia services that you pay before the services are actually provided can be reimbursed at the time the advance payment is actually made but only to the extent that you are required to make the advance payment to receive the services.

For purposes of Health Care FSA reimbursements, "dependent" includes:

(1) your spouse (as determined under federal law);

(2) your biological, adopted or step-child or your eligible foster child if the child will be younger than 27 on the last day of the calendar year in which the expense is incurred (even if the child is not your dependent for tax purposes); and

(3) any person who is expected to be your *dependent for federal income tax purposes* (as defined below) for the calendar year in which the expense is incurred.

For details on the requirements for someone to be your *dependent for federal income tax purposes*, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). The Plan Administrator always has the right to require documentation that an individual qualifies as your spouse or dependent for Health Care FSA purposes and to deny benefits if you fail to provide adequate documentation when required. If you have any question about whether someone qualifies as your dependent for purposes of the Health Care FSA, you should consult a tax advisor.

To be reimbursed from your Health Care FSA, you must submit to the Plan Administrator a request for reimbursement on a form provided by the Plan Administrator. You also must provide evidence of the amount, nature and payment of the underlying medical expense for which reimbursement is sought, as required by the Plan Administrator. Unless a later date is designated by the Plan Administrator, you must submit your requests no later than April 30 of the year following the Plan Year in which the expenses were incurred. Notwithstanding the preceding sentence, any such claim incurred during the 2022 Plan Year may be submitted within one hundred and twenty (120) days following July 10, 2023, which is the last date of the "Outbreak Period" as announced by the United States Department of Labor, Internal Revenue Service, and Department of the Treasury.

Health Care FSA Debit Card: You may be provided with a debit card that may be used to pay for eligible expenses directly from your Health Care FSA. If so, before you may use the debit card, you must agree in writing that you will use the card only to pay for eligible medical expenses for you or your spouse or dependents (as determined under federal tax law), that you will not use the debit card for any medical expense that has already been reimbursed, that you will not seek reimbursement under any other health plan for any expense paid with a debit card, and that you will obtain and keep sufficient records (including invoices and receipts) for any expense paid with the debit card. You may be required to provide receipts to the Plan to substantiate the expenses paid through a debit card. Also, as noted above, over-the-counter medicine (other than insulin) is not an eligible expense under a Health Care FSA unless it has actually been prescribed, so you generally will be required to provide a prescription if you wish to use the Health Care FSA debit card to purchase over-the-counter medicine. Some pharmacies or other vendors may not permit the use of a debit card to purchase over-the-counter medicine, even if you have a prescription. In addition, the Plan will comply with all applicable regulations and other authoritative guidance regarding the use of debit cards for Health Care FSA reimbursements, including substantiation requirements and correction procedures in the event that substantiation is not timely provided by the Participants. These correction procedures shall include reporting unsubstantiated amounts as wages on a Participant's Form W-2 where other correction methods fail. To the extent administratively practicable, all correction procedures shall be completed by the last day of the Plan Year. Additional details about the use of the debit card will be provided to you at the time the card is provided.

Health Care FSA Forfeitures: Please note that amounts held in your Health Care FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited, unless the amount is eligible to be carried over to the next Health Care FSA Plan Year, as described below.

Health Care FSA Carryover Feature: The Health Care FSA includes a "carryover" feature that provides that up to $500 of your unused balance in the Health Care FSA at the end of a Plan Year will not be forfeited but will instead be carried over to the next Plan Year (if you are still an eligible employee on the first day of the next Plan Year).

Example: If you elected to contribute $2,700 to your Health Care FSA for the 2019 Plan Year, but you have used only $2,100 of that amount when the Health Care FSA Plan Year ends on December 31, 2019 and you do not have any more eligible expenses to submit for reimbursement, the remaining $600 normally would have been forfeited because of the "use it or lose it" rule that applies to the Health Care FSA under federal tax law. With the carryover feature, you would still forfeit $100 of that unused balance but the remaining $500 will automatically be carried over to the Health Care FSA Plan Year that starts on January 1, 2020, so you can use that amount to pay eligible expenses you incur any time during the 2020 Health Care FSA Plan Year (while you are still an eligible employee).

Note that you can still elect to contribute the maximum amount permitted under the Health Care FSA for each Plan Year ($3,050 per Plan Year) even if you have an amount that is carried over from a previous year, so the carryover amount does not reduce the amount you can contribute each year. It just increases the amount available to you for the year.

Carried over amounts can still be used to pay expenses from the original Plan Year, as long as you submit your request for reimbursement before the deadline for submitting claims for that original Plan Year.

Example: If you used only $2,100 of your $2,700 contribution for the 2019 Plan Year by December 31, 2019, $500 of your unused balance would be carried over to the next Plan Year and could be used to reimburse expenses incurred during that Plan Year. However, if you still have expenses for the 2019 Plan Year that you need to submit for reimbursement, you still may submit those reimbursement requests and be paid up to $600 for those expenses, as long as you submit your request by the deadline for submitting expenses for that Plan Year.

Of course, if the $500 that was eligible for carryover is paid out to reimburse you for expenses incurred during the second plan year, it will no longer be available to pay expenses incurred during the original Plan Year. For that reason, it is important that you submit all requests for the original Plan Year first to make sure they are reimbursed first.

The carryover feature applies to the Health Care FSA, only, and does not apply to the Plan's Dependent Care FSA.

Dependent Care Flexible Spending Account (Dependent Care FSA). House Staff eligible to participate in the Plan may elect to have salary reduction contributions, in an aggregate amount not to exceed $5,000 per calendar year or, for married participants filing separately, $2,500 per calendar year, credited to your Dependent Care FSA. You can receive amounts from this Account, in cash, as reimbursement for Employment Related Expenses incurred during the Plan Year and while you are a participant in the Dependent Care FSA.

Coordination with Voucher Program and Backup Childcare Program. Note that your elections for the Dependent Care FSA may be limited based on your eligibility for and enrollment in the Plan Sponsor's Dependent Care Voucher Program and/or the Backup Childcare Program. The combination of benefits from the Child Care Voucher, the Dependent Care FSA, and Backup Childcare Program (or any other employer-provided day care benefit you receive) cannot exceed $5,000 per year. You are responsible for monitoring your usage of these funds at WEX. If you exceed $5,000 in any calendar year, the excess funds are reported as taxable income.

Reimbursements. The amount of any reimbursement for Employment Related Expenses may

not exceed the amount credited to your Account at the time of your reimbursement request. Generally, under federal law, "Employment Related Expenses" are expenses for household services and expenses related to the care of a "Qualifying Individual," which you incur to enable you to work.

"Qualifying Individual" is defined under federal law and currently means someone who is:

(1) your child (including a stepchild), brother, sister, stepbrother or stepsister (or a descendent of any of those, such as your grandchild or your niece or nephew) who is under the age of 13, who has the same principal residence as you for at least half of the calendar year and who does not provide at least half of their own support for the current calendar year,

(2) your spouse (for purposes of federal law) who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the calendar year or

(3) your *dependent for federal income tax purposes* (as defined below) who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the calendar year.

For details on the requirements for someone to be your *dependent for federal income tax purposes*, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). The Plan Administrator always has the right to require documentation that an individual qualifies as a Qualifying Individual under the above rules and to deny benefits if you fail to provide adequate documentation when required or if the Plan Administrator determines that expenses for any person are not eligible for reimbursement. If you have any question about whether someone qualifies as your dependent for purposes of the Dependent Care FSA, you should consult a tax advisor. Also, note that the determination of whether someone is a Qualifying Individual must be made each time expenses are incurred. For example, if your child is age 12 at the start of the calendar year, otherwise eligible expenses for that child can be reimbursed under the Dependent Care FSA only for services provided <u>before</u> the child's 13th birthday (unless the child is mentally or physically incapable of taking care of himself or herself).

The amount of reimbursements that you may receive from your Dependent Care FSA on a tax-free basis in a calendar year cannot exceed the lesser of your Earned Income (as defined in the Plan) or your spouse's Earned Income. Any amount that you receive in excess of that amount will be taxable to you. Thus, for example, if you have $5,000 in your Dependent Care FSA and you and your spouse have Earned Income of $20,000 and $4,000, respectively, you can receive $4,000 worth of reimbursement from the Account on a tax-free basis, and you will be taxed on $1,000 worth of the reimbursement you receive. If your spouse is either a full-time student or is incapable of self-care, your spouse will be deemed to have Earned Income for each month that he or she is a full-time student or incapacitated. The amount of deemed earnings will be $250 a month, if you provide care for one Qualifying Individual, or $500 a month, if you provide care for more than one Qualifying Individual.

Employment Related Expenses that are incurred for services outside your household may be reimbursed only if incurred for the care of (i) a Qualifying Individual who is a qualifying child under thirteen years of age (category (1) in the above definition of Qualifying Individual), or (ii) another Qualifying Individual who regularly spends at least eight hours each day in your household. In addition, if the services are provided by a Dependent Care Center (as defined below), the Center must comply with applicable laws and regulations of a state or local government. A "Dependent Care Center" is any facility that provides care for more than six individuals who do not reside at the center and receives a fee, payment or grant for

providing services for any of the individuals.

No reimbursements will be made for Employment Related Expenses for services rendered by any person for whom you or your spouse is entitled to a deduction on your federal income tax return for the applicable calendar year or who is your child (including a stepchild or a foster child) who will be under the age of 19 at the end of the year.

Filing Claims for Benefits. The Dependent Care FSA is administered by WEX. To be reimbursed from your Dependent Care FSA, you must submit a reimbursement request to WEX and provide evidence of the amount, nature and payment of the underlying expense for which reimbursement is sought.

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

Here are different ways to file a claim for reimbursement from your Dependent Care FSA:

- Use your WEX debit card (if provider accepts debit cards).
- Complete and submit the Recurring Dependent Care Request Form.
- Pay your care provider and if possible, obtain a receipt.
- Complete a Claim Form, available at www.wexinc.com.

If you complete a Claim Form, attach a dated receipt to the form, and send both to the address shown on the form. Your receipt can be a bill, an invoice or a receipt only. You can have your Dependent Care FSA reimbursement checks mailed to you or you can elect direct deposit of these amounts into your checking or savings account. To use the direct deposit feature you will need to complete the direct deposit setup from your online account. You can be reimbursed only up to the amount in your account at the time you file a claim. If your claim exceeds the balance in your account, the outstanding amount will be carried over and paid automatically as new contributions are added to your account. However, if you terminate participation during the year, you will not be reimbursed for claims incurred after your termination of participation

Use It or Lose It. It is important to plan your contributions to the Dependent Care FSA carefully. The IRS requires that you must use the full amount of money in your dependent care flexible spending account for expenses incurred during the plan year, or forfeit what remains. You must incur eligible expenses within the plan's timeframe – no later than March 15 of the following plan year, or two and a half months after the end of the plan year – in order for them to be eligible for reimbursement. Unless a later date is designated by the Plan Administrator, you must submit such requests by April 30 of the following plan year. Please note that amounts held in your Dependent Care FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited.

Miscellaneous. Under the Internal Revenue Code, you also may reduce your taxes by taking a dependent care tax credit. However, any amounts which you exclude from income under the Dependent Care FSA will reduce, dollar for dollar, the tax credit available. You should consult a tax advisor to determine which tax reduction method is more beneficial for you.

Dependent Care FSA benefits are not subject to the federal law known as ERISA, so the "Your Rights under ERISA" section of this SPD does not apply to these benefits.

Childcare Centers. Each eligible Participant will receive access to our on-site childcare partners: Homewood Early Learning Center, Harry and Jeanette Weinberg Early Childhood Center, and Johns Hopkins Child Care and Early Learning Center (Bright Horizons). Scholarships are available for full-time post-doctoral fellows, doctoral or medical students, and house staff (including residents and interns) based on your family's adjusted gross income. Additional details appear in the Benefits Booklets (see Appendix A).

COBRA CONTINUATION COVERAGE RIGHTS & CONVERSION RIGHTS

If you receive health care benefits under the Plan, you may have the right to continue to receive these benefits even if your normal coverage under the Plan ends. In addition, if any of your health care benefits are provided through insurance, you may have the right to convert your coverage for those benefits from the group policy to an individual policy. If you would like more information regarding your health care continuation or conversion rights, please contact the Plan Administrator. Also, please review the next section regarding continuation coverage under the federal law known as "COBRA".

COBRA General Notice

This "COBRA General Notice" section of your SPD applies to employees and covered spouses and dependents who have health coverage under the Plan and has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This notice is provided to meet federal requirements that plan participants receive a copy of the COBRA general notice within 90 days of enrollment in the Plan.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For purposes of this notice, "Plan" refers only to the medical, prescription drug, dental, vision, employee assistance program, onsite clinic, and health care flexible spending account benefits described in this SPD and this notice is not intended to apply to any other type of benefit. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator, Johns Hopkins University. Plan Administrator correspondence should be mailed to:

The Johns Hopkins University
Office of Benefits Services, Attn: Student Benefits Team
Johns Hopkins at Eastern
1101 E. 33rd Street, Suite D200
Baltimore, Maryland 21218
Telephone number: **410-516-2000**
E-mail: JHUStudentBenefits@jhu.edu

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

Please note:

- Under federal law, COBRA does not apply to coverage of domestic partners and their dependents, but the Employer voluntarily provides similar continuation coverage benefits for covered domestic partners who would otherwise lose coverage because of an event that would be considered a COBRA qualifying event for a covered spouse. Because this coverage is not required by applicable law, the Administrator reserves the right to terminate or modify this voluntary continuation coverage at any time.
- The following is only a summary of certain important provisions of COBRA. If you experience a COBRA "qualifying event" and provide required notice to the COBRA Administrator by the applicable deadline, you will receive a COBRA Notice with additional information.
- COBRA is administered by WEX, which is referred to in this section as the COBRA Administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of health coverage under the Plan when coverage would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both;

You must give the Plan Administrator Notice of Some Qualifying Events.

For all other qualifying events (<u>divorce</u> or <u>legal separation</u> of the employee and spouse or a <u>dependent child's losing eligibility for coverage</u> as a dependent child), you must notify the Plan Administrator within 60 days after the later of (1) the date the qualifying event occurs or (2) the date coverage would end because of the qualifying event. This notice must be provided, along with any required documentation to:

The Johns Hopkins University
Office of Benefits Services, Attn: Student Benefits Team
Johns Hopkins at Eastern
1101 E. 33rd Street, Suite D200
Baltimore, Maryland 21218
Telephone number: **410-516-2000**
E-mail: JHUStudentBenefits@jhu.edu

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

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

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

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

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will

have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. (*NOTE: The rest of this paragraph applies to health plans other than a health care flexible spending account plan. For the rules that apply for a health care flexible spending account, see the "Special Rules for Health Care Flexible Spending Accounts" section below.*) When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended, as described in the next two sections of this Notice.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To notify the Plan Administrator of the Social Security Administration's disability determination, you should follow the same procedures described above under "*You Must Give the Plan Administrator Notice of Some Qualifying Events*". Your notice must include documentation of the Social Security Administration's decision and it must be provided within 60 days after the date of that decision, or, if later, within 60 days after the later of (1) the date the original qualifying event occurred or (2) the date that coverage would otherwise end (if COBRA coverage is not elected) because of the original qualifying event. However, regardless of the deadline described in the previous sentence, your notice must be provided no later than the date your COBRA coverage would terminate if you failed to qualify for a disability extension.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event (following the same procedures described above under "*You Must Give Notice of Some Qualifying Events*"). This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first

qualifying event not occurred.

Special rules for health care flexible spending accounts

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

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

Any filing deadlines or other rules for filing a request for reimbursement under the Health Care FSA, as described earlier in this SPD, will continue to apply if you elect continuation coverage under the Health Care FSA.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[2] to sign up for Medicare Part A or B, beginning on the earlier of

[2] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

- The month after your employment ends.
- The month after group health plan coverage based on current employment ends

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

If you have questions or need more information about COBRA continuation coverage under the Plan, please contact the Plan Administrator at the address or phone number provided in this SPD.

IMPORTANT LEGAL NOTICES

The Newborns' and Mothers' Health Protection Act

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

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

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

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

Women's Health and Cancer Rights Act of 1998

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

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator [insert phone number].

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

Qualified Medical Child Support Orders

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

Medicare Part D Prescription Drug Creditable Coverage

If you or a covered dependent are eligible for prescription drug coverage under the Plan and are also

eligible for Medicare, a federal law called the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the employer to provide you with an annual notice (Notice) addressing whether the Plan's prescription drug coverage is creditable or non-creditable. You should receive the Notice each year by October 15.

Creditable means that the Plan's prescription drug coverage is expected to pay out, on average, as much or more as the standard prescription drug benefit under Medicare Part D will pay. You don't need to enroll in coverage under Medicare Part D if your coverage under the Plan is creditable.

However, if your coverage under the Plan is non-creditable, you may pay higher Medicare Part D premiums if you have a break in creditable coverage of 63 days or more and then enroll in Medicare Part D prescription drug coverage.

Additional information about your prescription drug coverage under the Plan is available in the Notice that you receive. The Notice is intended to help you decide between Medicare Part D prescription drug coverage or employer-provided coverage, if available. You can also request a copy of the Notice by contacting the Plan Administrator.

OTHER RIGHTS

Emergency Medical Care

If you believe you need emergency medical care, you should not forego that care because you believe it will not be covered by the Plan.

Patients to Evaluate Care

The Employer assumes no responsibility for the medical care reimbursed by the Plan which is provided by any practitioner. Each patient should evaluate the quality of care and act accordingly. No Plan provision expressed in this SPD or the Plan documents should be interpreted to restrict the access to or delivery of medically necessary services. A patient's decision to forego such care should not be based on their interpretation of this SPD or the Plan documents.

Health Information Privacy under HIPAA

The receipt, use and disclosure of protected health information by the medical benefit, prescription drug benefit, dental benefit, vision benefit, employee assistance program and Health Care FSA portions of the Plan is governed by regulations issued under the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH"). In accordance with these regulations, the Plan Administrator, certain employees working with, and on behalf of, the Plan and the Plan's business associates may receive, use and disclose protected health information in order to carry out the payment, treatment and health care operations under of the Plan. These entities and individuals may use protected health information for such purposes without your consent or authorization. In addition, your protected health information may be shared with the Plan Sponsor without your consent or written authorization for administrative purposes. If your protected health information is used or disclosed for any other purpose (other than as specifically required or authorized under HIPAA), the Plan must first obtain your written authorization for such use or disclosure. For more information about the privacy of your protected health information under HIPAA, see the Plan's Notice of Privacy Practices, which has been distributed to you and for which a copy may be requested by contacting the Plan Administrator.

CLAIMS PROCEDURES

The following summary of the Plan's claims procedures is intended to reflect the Department of Labor's claims procedures regulations and the applicable requirements of regulations issued under the Affordable Care Act and should be interpreted accordingly. If there is any conflict between this summary and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the Plan automatically effective on the date of those changes.

For purposes of this claims procedure section, the term "Claims Administrator" means the person(s) or entities that the Plan Administrator authorizes and delegates the power and responsibility to review claims and determine benefits under the Plan. A Claims Administrator may include an Insurer or a third-party administrator for a particular benefit under the Plan. For any insured benefits or any other benefits for which the Plan Administrator has delegated the power and responsibility to determine claims and benefits to a Claims Administrator, that Claims Administrator's claims procedures generally will apply instead of the claims procedures described in this SPD. This Claims Procedure section includes descriptions of the minimum requirements for claims procedures that apply to insured benefits, but full details of claims procedure rules for insured benefits are described in the Insurer's Benefits Booklet that describes the specific benefit. If you have questions about claims procedures for any insured benefit, you should contact the Insurer directly.

Note that, for any claim for a benefit under the Plan that is not subject to ERISA, the Department of Labor's regulations do not apply. For those claims, including claims for dependent care flexible spending account benefits, the claims procedures described in this section that apply for benefits other than health or disability benefits will apply, but any requirement that the Plan Administrator (or an Insurer) provide notice to a Claimant about any right under ERISA will not apply to such a claim. For purposes of this claims procedure section, the term "Claimant" means a participant, dependent or beneficiary who believes he or she is eligible for any benefit under the Plan and makes a claim or appeal for those benefits.

To receive Plan benefits, you must follow the procedures established by the Plan Administrator and/or the Claims Administrator which has the responsibility for making the particular benefit payments to you. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

Claims and Appeals Procedures

If your claim for benefits (Urgent Care, Pre- or Post-Service) is denied in whole or in part, or if you are the subject of a Rescission Determination, the procedures in this section must be followed and your appeal rights must be exhausted before you may file suit in court. You, your Authorized Representative or your Health Care Provider may also have the right to file a Complaint with the Maryland Insurance Commissioner as explained below under "**Filing Complaints with the Commissioner**". Once your claim has been filed, it will be processed as set forth below and you, your Authorized Representative or your Health Care Provider will be notified of the decision in writing. Notice of the decision will also be orally communicated if it involves a utilization review determination that a proposed or delivered health care service is or was not medically necessary, appropriate or efficient, and the determination may result in noncoverage of the health care service. When notice is orally communicated, written notice of the decision will be provided within five working days after the decision is made, except that in the case of an Urgent Care Claim written notice of the decision will be provided within one day after the decision is made.

All notices of claim decisions, whether oral or written, will be provided in a manner calculated to be understood by you, your Authorized Representative or your Health Care Provider, and will be provided in

a culturally and linguistically appropriate manner as required by regulations under the Affordable Care Act. Notices will state the name, business address and business telephone number of a Plan employee responsible for the Claims and Appeals process, and will include a description of the right to file a Complaint with the Maryland Insurance Commissioner within four months after receipt of the notice of the decision. Notices will include the Commissioner's address, telephone number and fax number. Notices will include a statement that the Health Advocacy Unit is available to assist you or your Authorized Representative in both mediating and filing appeals under these procedures, and will include the address, telephone number, fax number and email address of the Health Advocacy Unit.

Adverse Determination

For purposes of this Claims Procedure section, an "adverse determination" is any denial, reduction, or termination of, or a failure by the Plan to provide or make payment (in whole or in part) for, a benefit, including any such decision that is based on a determination of an individual's eligibility to participate in a benefit under the Plan. For any coverage that is subject to the Affordable Care Act, "adverse determination" also includes any rescission of coverage. A rescission of coverage generally is a retroactive termination of coverage because of fraud or for misrepresentation of a material fact. Note that a termination of coverage for failure to pay any required contributions is not considered a rescission and is not subject to these claims procedures even if it is effective retroactive to the date through which coverage was paid for. Whether a termination of coverage is considered a "rescission" and is therefore an adverse determination that is subject to these claims procedures will be determined by the Claims Administrator based on applicable law.

Eligibility Claims

Eligibility claims are those claims that relate to your participation in the Plan or the change of an election to participate during the Plan Year. If a claim relates to your enrollment in or eligibility to participate in the Plan (as opposed to what benefits you or your dependents are eligible for under the Plan), you, your dependent or beneficiary may contact the Plan Administrator to initiate an eligibility claim as soon as possible, but no later than 60 days after your eligibility has been denied. Your eligibility claim will be reviewed and the Plan Administrator will send you a letter approving or denying your eligibility claim within 90 days of receipt of the claim. If your eligibility claim is denied on review, you may appeal the denial in writing to the Plan Administrator within 60 days of receiving the denial and the Plan Administrator will make a decision within 60 days of receiving your appeal. Once the Plan Administrator makes a decision on your appeal in its sole discretion, that decision is final and you have no further appeal rights.

Initial Benefit Claims

Initial claims for Plan benefits are made to the Claims Administrator responsible for adjudicating claims for a particular benefit. All claims must be submitted, in writing (except to the extent that oral claims are permitted for urgent care claims, as described below), to the Claims Administrator. Claims should be submitted promptly after an expense is incurred. Unless a later deadline expressly applies in this SPD or under a Benefits Booklet or insurance contract, no initial claim for any benefit will be accepted, processed or paid for any expense if the initial claim is submitted later than 18 months after the date the expense was incurred. (For deadlines for submitting flexible spending account reimbursement requests, see the "Summary of Available Benefits" section of this SPD.)

The Claims Administrator will review the claim itself or appoint an individual or an entity to review the claim, following the following procedures. (For purposes of these procedures, "health benefits" or "health claims" refers to benefits or claims involving medical, dental, vision or health care flexible spending account coverage.)

(a) Non-Health and Non-Disability Benefit Claims. For any claim that is not a health claim or a disability claim, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Claims Administrator before the end of the 90-day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Health Benefit Claims. If the Claim is for urgent care health benefits, the Claims Administrator will notify whoever filed the claim (referred to as the "Claimant") of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In cases where the Claimant fails to provide sufficient information to decide the claim, the Claims Administrator will notify the Claimant by telephone as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The caller will offer to assist the claimant, the claimant's representative or the health care provider in gathering the necessary information. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information. The decision on the claim will take into account all the information available to the Plan. If an Urgent Care Claim involves a request to extend an approved course of treatment, and the request is received at least 24 hours before the end of the approved course of treatment, the claimant will be orally notified of the decision within 24 hours. In either case, written notification will be sent to the claimant within one day after oral notice is given.

A health benefits claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. The Plan will defer to a determination, if any, by a qualified attending provider that a claim qualifies as an urgent care claim based on the definition summarized in the preceding sentence.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Claims Administrator will notify the Claimant of the adverse determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments will be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Health Benefit Claims. For any health benefit claim not described above:

(A) For any pre-service health benefit claim, the Claims Administrator will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim, but not later than five days after the decision has been made. If, due to special circumstances, the Claims Administrator needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the Claims Administrator expects to make its decision. Under no circumstances may the Claims Administrator extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information. The decision on the claim will take into account all the information available to the Plan.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

If the Claims Administrator approves a pre-service claim, the Plan may not deny reimbursement to the health care provider for the approved treatment delivered to the patient unless:

- The information submitted regarding the treatment was fraudulent or intentionally misrepresentative;
- Critical information required by the Claims Administrator was omitted such that the Claims Administrator's determination would have been different had it known the critical information;
- The preauthorized course of treatment for the patient was not substantially followed by the health care provider; or
- On the date the preauthorized treatment was delivered:
  - the patient was not covered by the Plan;
  - The Plan maintained an automated eligibility verification system that was available to the health care provider by telephone or via the Internet; and
  - according to the verification system, the patient was not covered by the Plan.

If a Pre-Service Claim involves an initial determination regarding a nonemergency course of treatment, the decision will be made within two working days after receipt of the information necessary to make the decision, and your provider will be promptly notified of the decision.

If a Pre-Service Claim involves an extended stay in a health care facility or additional health care services, the decision will be made within one working day after receipt of the information necessary to make the decision, and your provider will be promptly notified of the decision.

If within three calendar days after receipt of the initial request for health care services the Plan does not have sufficient information to make a determination, it will inform the health care provider that additional information must be provided.

If prior authorization is required for an emergency inpatient admission, or an

admission for residential crisis services for treatment of a mental, emotional or substance abuse disorder, the Plan will make all determinations on whether to authorize or certify such an inpatient admission or admission for residential crisis services within two hours after receipt of the information necessary to make the determination, and will promptly notify the health care provider of the determination.

(B) For any post-service health benefit claim, the Claims Administrator will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim, and not later than five days after the decision has been made. If, due to special circumstances, the Claims Administrator needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan receives the claim, of those special circumstances and of when the Claims Administrator expects to make its decision. Under no circumstances may the Claims Administrator extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information. The decision on the claim will take into account all the information available to the Plan.

A health benefit claim is considered a post-service claim if it is a request for payment for services or other benefits already provided (or any other health benefit claim that is not a pre-service claim).

(c) Disability Benefit Claims. For any disability benefits claim, the Claims Administrator will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 45 days after receipt of the claim. If, due to matters beyond the control of the Plan, the Claims Administrator needs additional time to process a claim, the Claimant will be notified, within 45 days after the Claims Administrator receives the claim, of those special circumstances and of when the Claims Administrator expects to make its decision but not beyond 75 days. If, before the end of the extension period, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to 105 days, provided that the Claims Administrator notifies the Claimant of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. The extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the Claimant to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

(d) Manner and Content of Denial of Initial Claims. If the Claims Administrator denies a claim, it will provide to the Claimant a written or electronic notice that includes:

(i) A description of the specific reasons for the denial or rescission;

(ii) A reference to any Plan provision or insurance contract provision and factual bases upon which the denial or rescission is based;

(iii) A description of any additional information that the Claimant must provide in order to perfect the claim (including an explanation of why the information is needed);

(iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial;

(v) A statement of the Claimant's right to bring a civil action under ERISA following any denial on review of the initial denial.

In addition, for a denial of health benefits or disability benefits, the following will be provided to the Claimant:

(i) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the Claimant and without charge). The notice will reference the specific criteria and standards, including interpretive guidelines, on which the decision was based, and will not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure" or "not medically necessary"; and

(ii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that the same will be provided upon request by the Claimant and without charge).

In addition, for a denial of a claim for disability benefits, the following must be provided:

(i) a discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant, if those views were presented by the Claimant to the Plan; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made on the Claimant's behalf by the Social Security Administration, if that determination was presented by the Claimant to the Plan;

(ii) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and

(iii) a statement that the Claimant is entitled to bring a civil action in federal court under ERISA Section 502 to pursue the Claimant's claim for benefits, and a description of any contractual limitations period that applies to the Claimant's right to bring an action and the calendar date on which the contractual limitations period expires for the claim.

Note that an adverse determination shall include rescissions of disability coverage, regardless of whether the rescission had an adverse effect on any particular benefit, unless it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

For an adverse determination concerning a health claim involving urgent care, the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than three days after the oral notification. If a claim is denied, the notice will state that you, your Authorized Representative or your Health Care Provider have the right to file a Complaint with the Maryland Insurance Commissioner within four months after receipt of a denial of a first level appeal, as explained below under **Filing Complaints with the Commissioner**. The Final Appeal process does not have to be completed before filing a Complaint with the Commissioner. The notice will also state that you, your Authorized Representative or your Health Care Provider have the right to file a Complaint with the Commissioner without completing the first level appeal process, for the reasons set forth below under **Filing Complaints**

with the Commissioner. The notice will state the name, business address and business telephone number of a Plan employee responsible for the Claims and Appeals process. The notice will include the Commissioner's address, phone number and fax number, a statement that the Health Education and Advocacy Unit is available to assist you, your Authorized Representative or your Health Care Provider in both mediating and filing an appeal under the Program's Claims and Appeals process, and the Health Education and Advocacy Unit's address, phone number, fax number and email address.

Authorized Representative and Health Care Provider

Your Authorized Representative or your Health Care Provider may file a claim, appeal a denial of benefits, or file a Complaint with the Maryland Insurance Commissioner for you. A Health Care Provider is an individual acting on your behalf who has provided treatment to you and who is licensed under Maryland or other state law to provide health care services in the ordinary course of business or practice of a profession, and includes a licensed hospital.

Reviews of Initial Adverse Determinations

If you or your Authorized Representative submit a claim for Plan benefits and it is initially denied under the procedures described above, you, your Authorized Representative or your Health Care Provider may request a review of that denial under the following procedures. For purposes of this claims procedure section, the term "Appeals Manager" means the person(s) or entities that the Plan Administrator authorizes and delegates the power and responsibility to review denied claims and appeals under the Plan. An Appeals Manager may include an Insurer or a third-party administrator for a particular benefit under the Plan. You may also request a review if you are the subject of a Rescission Determination.

If a first level appeal is denied, the notice will state that you, your Authorized Representative or your Health Care Provider have the right to file a Complaint with the Maryland Insurance Commissioner within four months after receipt of a denial of the first level appeal, as explained below under **Filing Complaints with the Commissioner**. The final appeal process does not have to be completed before filing a Complaint with the Commissioner. The notice will also state that you, your Authorized Representative or your Health Care Provider have the right to file a Complaint with the Commissioner without completing the first level appeal process, for the reasons set forth below under **Filing Complaints with the Commissioner**. The notice will state the name, business address and business telephone number of an Employer Health Programs employee responsible for the Claims and Appeals process. The notice will include the Commissioner's address, phone number and fax number, a statement that the Health Education and Advocacy Unit is available to assist you, your Authorized Representative or your Health Care Provider in both mediating and filing an appeal under the Program's Claims and Appeals process or in filing a Complaint with the Commissioner, and the Health Education and Advocacy Unit's address, phone number, fax number and email address.

<u>Note</u>: if you file a Complaint with the Maryland Insurance Commissioner after receipt of a denial of the first level appeal as explained above, doing so does <u>not</u> extend the time deadline for filing a final appeal. Failure to timely file a Final Appeal means you lose all rights to appeal. However, failure to timely file a final appeal does not affect your right to pursue your Complaint with the Maryland Insurance Commissioner.

(a) <u>Non-Health and Non-Disability Benefit Claims</u>.

For benefits other than health and disability benefits, a request for review of a denied claim must be made in writing to the Appeals Manager within 60 days after receiving notice of the initial denial

of the claim. The decision on review will be made within 60 days after the Appeals Manager's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review.

The Appeals Manager will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Appeals Manager. The Appeals Manager will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(b) Health and Disability Benefit Claims. A Claimant whose initial claim for health or disability benefits is denied may request a review of that denial no later than 180 days after the Claimant receives the notice of an adverse determination. Certain benefits may allow for two levels of appeal, in which case, a request for a second review of a denial must be submitted no later than 60 days after the Claimant receives the notice of the first adverse determination on review. Except as provided below for an expedited review of a denied urgent care health claim, a request for review must be submitted to the Appeals Manager in writing.

A Claimant may request an expedited review of a denied initial urgent care health claim. Such a request may be made to the Appeals Manager orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Appeals Manager and the Claimant by telephone, facsimile or other available similarly expeditious method.

In addition to providing the right to review documents and submit comments as described in (a) above, a review will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial adverse determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual. The health care professional will be (i) a licensed physician who is board certified or eligible in the same specialty as the treatment involved in the claim under review, or (ii) a panel of other appropriate health care service reviewers with at least one licensed physician on the panel who is board certified or eligible in the same specialty as the treatment involved in the claim under review. If the claim involves a mental health or substance abuse service, the health care professional will be (i) a licensed physician who (1) is board certified or eligible in the same specialty as the treatment involved in the claim under review or (2) is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review, or (ii) a panel of other appropriate health care service reviewers with at least one licensed physician on the panel who (1) is board certified or eligible in the same specialty as the treatment involved in the claim under review or (2) is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

(iv) For purposes of any medical coverage that is subject to the Affordable Care Act or any disability benefit claims, the Plan or Appeals Manager will allow a Claimant to review the claim file and to present evidence and testimony and will comply with the following additional requirements:

(A) The Plan or the Appeals Manager will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or Appeals Manager in connection with the claim as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable regulations) to give the Claimant a reasonable opportunity to respond before that date; and

(B) Before the Plan or Appeals Manager issues a final decision on review based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for the Plan's decision as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable regulations) to give the Claimant a reasonable opportunity to respond before that date.

(c) Deadline for Review Decisions.

(i) Urgent Care Health Benefit Claims. For urgent care health claims, the Appeals Manager will notify the person filing the Appeal of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Claimant's request for review of the initial adverse determination, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. If the appeals department needs more information to decide a first level appeal of an Urgent Care Claim, the claimant will be told by telephone within 24 hours what additional information is needed and will have 48 hours to supply it. The caller will offer to assist the claimant, the claimant's representative or the health care provider in gathering the necessary information. The time limit for the appeals department to decide the first level appeal of an Urgent Care Claim is suspended until the claimant supplies the additional information. For any benefits that provide for two mandatory levels of internal appeal, such notice will be provided for each level of appeal as soon as possible, taking into account medical exigencies, but not later than 36 hours after the Plan or an Appeals Manager receives the Claimant's request for review of the previous adverse determination.

(ii) Other Health Benefit Claims.

(A) For a pre-service health claim, the Appeals Manager will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives the Claimant's request for review of the initial adverse determination. For any benefits that provide for two mandatory levels of internal appeal, such notice will be provided for each level of appeal no later than 15 days after the Plan or an Appeals Manager receives the Claimant's request for review of the previous adverse determination.

(B) For a post-service health claim, the Appeals Manager will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than

60 days after the Plan receives the Claimant's request for review of the initial adverse determination. For any benefits that provide for two mandatory levels of internal appeal, such notice will be provided for each level of appeal no later than 30 days after the Plan or an Appeals Manager receives the Claimant's request for review of the previous adverse determination.

(iii) Disability Benefit Claims. For disability claims, the decision on review will be made within 45 days after the Appeals Manager's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review.

(d) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial claim determination, the Appeals Manager will provide the person filing the appeal a written notice of its decision on review. Notice of the decision will be given orally if it involves a utilization review determination that a proposed or delivered health care service is or was not medically necessary, appropriate or efficient, and the determination may result in noncoverage of the health care service. When oral notice is given, written notice of the decision will be provided within five working days after oral notice is given, or within one working day if the Appeal relates to an Urgent Care Claim. For any adverse determination on review, that notice will include:

(i) a description of its decision;

(ii) a description of the specific reasons for the decision;

(iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;

(iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claim for benefits;

(v) if applicable, a statement describing the Claimant's right to bring an action for judicial review under ERISA Section 502(a);

(vi) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and

(vii) if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request; and

(viii) Additionally, for a denial of a claim for disability benefits, the following must be provided:

(A) a discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant, if those views were presented by the Claimant to the Plan; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made on the Claimant's behalf by the

Social Security Administration, if that determination was presented by the Claimant to the Plan;

(B) a statement that the Claimant is entitled to bring a civil action in federal court under ERISA Section 502 to pursue the Claimant's claim for benefits, and a description of any contractual limitations period that applies to the Claimant's right to bring an action and the calendar date on which the contractual limitations period expires for the claim.

Additional Requirements for Medical Plan Claims or, as Applicable, Disability Benefit Claims

For any adverse determination involving medical coverage (or, as applicable, disability benefit claims), any notice of an adverse determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and will include (in addition to other requirements described above):

(1) information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's, Claims Administrator's or Appeals Manager's standard, if any, that was used in denying the claim;

(3) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Affordable Care Act to assist individuals with internal claims and appeals and external review processes; and

(5) a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Also, for all claims involving coverage that is subject to the Affordable Care Act or for any disability benefit claims, the Plan will ensure that claims and appeals are decided in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the denial of benefits.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim or appeal is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary for an initial claim for health benefits (other than urgent care benefits) or for disability benefits, the period for making the determination will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds.

Claimant's Failure to Follow Procedures

Except to the extent that a Claimant is deemed to have exhausted the Plan's claims procedures due

to the Plan's failure to follow the claims procedures under ERISA, a Claimant must follow the claims procedures described above to be entitled to file any legal action for benefits under the Plan.

External Review

External review is available for final adverse determinations involving (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer, or (2) rescission of coverage (i.e., a retroactive termination of coverage, whether or not the rescission has any effect on any particular benefit at the time). Claimants in urgent care situations and those receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process. External review is not available for final adverse determinations that relate to a failure to meet the eligibility requirements under the Plan. External review procedures are detailed in the applicable Benefit Booklets that relate to medical benefits.

Insured Benefits and State Law

For any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Filing Complaints with the Commissioner

When a Complaint Can Be Filed

Within four months after receipt of a first level appeal decision (including a decision involving a Rescission Determination), you, your Authorized Representative or your Health Care Provider may file a Complaint with the Commissioner of the Maryland Insurance Administration for review of the first level appeal decision.

You, your Authorized Representative or your Health Care Provider may file a Complaint with the Commissioner without filing a first level appeal or receiving a first level appeal decision if:

- The Plan Administrator waives the requirement that the internal Claims and Appeals process be exhausted before filing a Complaint with the Commissioner;

- The Plan Administrator has failed to comply with any of the requirements of the internal Claims and Appeals process;

- You, your Authorized Representative or your Health Care Provider provides a compelling reason to do so as determined by the Commissioner. For example, you, your Authorized Representative or your Health Care Provider could provide sufficient information and supporting documentation in the Complaint to demonstrate that the potential delay in receipt of a health care service until after exhaustion of the internal Claims and Appeals process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the patient remaining seriously mentally ill with symptoms that cause the patient to be a danger to self or others;

- The Complaint involves an Urgent Care Claim condition for which care has not been rendered; or

- You, your Authorized Representative or your Health Care Provider do not receive the Program's decision on an appeal within the following timeframes:
  - Within 30 days after the filing date of an appeal regarding a Pre-Service Claim
  - Within 45 days after the filing date of an appeal regarding a Post-Service Claim
  - Within 24 hours after the receipt of an appeal regarding an Urgent Care Claim.

How Complaints are Handled

The following provisions generally describe the Commissioner's handling of Complaints. Actual handling of Complaints will be made in accordance with Md. Insurance Code Ann. § 15-10A-03 and §15-10D-02.

- The Commissioner will notify the Plan Administrator of the Complaint within five working days after the date the Complaint is filed with the Commissioner.

- Except for an Urgent Care condition, the Plan Administrator will provide to the Commissioner any information requested by the Commissioner no later than seven working days from the date the Plan Administrator receives the request for information.

- Except as provided below, the Commissioner will make a final decision on a Complaint:
  - within 45 days after a Complaint is filed regarding a Pre-Service Claim
  - within 45 days after a Complaint is filed regarding a Post-Service Claim
  - within 24 hours after a Complaint is filed regarding an Urgent Care Claim.

- The Commissioner may extend the period within which a final decision on a Complaint is to be made for up to an additional 30 working days if the Commissioner has not yet received information requested by the Commissioner and the information requested is necessary for the Commissioner to render a final decision on the Complaint.

- The Commissioner will seek advice from an independent review organization or medical expert for Complaints filed with the Commissioner that involve a question of whether a treatment is medically necessary.

- The Plan Administrator will have the burden of persuasion that its claim denial or Appeal decision (including a Rescission Determination) is correct during the review of a Complaint by the Commissioner, and in any hearing held regarding the Complaint.

- As part of the review of a Complaint, the Commissioner may consider all of the facts of the case and any other evidence deemed relevant.

- In responding to a Complaint, the Plan Administrator usually may not rely on any basis not stated in its claim denial or appeal decision. However, the Commissioner may allow the Plan Administrator, you or your Authorized Representative or Health Care Provider to provide additional information as may be relevant for the Commissioner to make a final decision on the Complaint. The Commissioner will allow you, your Authorized Representative or your Health Care Provider at least five working days to provide the additional information. The

Commissioner's use of additional information may not delay the Commissioner's decision on the Complaint by more than five working days.

- The Commissioner will require you or your Authorized Representative to sign a consent form authorizing the release of your records to the Commissioner that are needed in order for the Commissioner to make a final decision on the Complaint.

- The Commissioner may delegate the authority to review and decide Complaints to any person, including an administrative law judge.

Assistance from Health Education and Advocacy Unit

The Health Education and Advocacy Unit is available to assist you, your Authorized Representative or your Health Care Provider in both mediating and filing an appeal. Contact the Health Education and Advocacy Unit at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
410- 528-1840 or 1-877- 261-8807
Fax: 410- 576-6571
E-mail: heau@oag.state.md.us

STATUTE OF LIMITATIONS FOR PLAN CLAIMS

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator, Claims Administrator or Appeals Manager, as applicable, has been rendered (or deemed rendered). Any such action must be brought in federal district court in the state of Maryland.

TERMINATION OR AMENDMENT OF PLAN

The Plan Sponsor expects to maintain the Plan indefinitely as a program of employee benefits. However, the Plan Sponsor, or its delegate, has the right, in its sole discretion, to terminate or amend any provision of the Plan at any time. Therefore, no Plan participant (including any future retiree or retiree who has already retired) has a right to the continued enjoyment of any particular benefit under the Plan after a Plan termination or amendment affecting those benefits.

NO RIGHT TO CONTINUED EMPLOYMENT

No provision of the Plan or this SPD shall be interpreted as giving any employee any rights of continued employment with the Employer or in any way prohibiting changes in the terms of employment of any employee covered by the Plan.

NO VESTED RIGHTS

The Plan creates no vested rights of any kind. No person shall have any right, title or interest in or through the Plan, except as specifically provided in this SPD. Nothing shall be construed as giving any

person rights against the Plan, the Plan Sponsor, the Plan Administrator, any Employer or any of their employees and agents, except as provided in this SPD.

NON-ASSIGNMENT OF BENEFITS

The right of any “covered person" (this term is used to refer to any individual participating in this Plan, including employees and their dependents) to: (1) receive any benefit under this Plan; (2) appeal any claim for denied benefits; (3) request copies of Plan documents as permitted by ERISA; and/or (4) bring any legal claim under ERISA, including but not limited to, claims for: (i) benefits under the Plan; (ii) breach of fiduciary duty; and (iii) statutory penalties, shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind to any third party, including any medical service provider, and any attempt to do so will be void. Furthermore, any such right to receive Plan benefits may not be levied upon or otherwise taken or attached by any creditor in any voluntary or involuntary proceeding, and any attempt to cause such right to be so subjected will not be recognized, except to the extent as may be required by law.

Notwithstanding the foregoing, a covered person may direct, in writing, that benefits payable to him or her be paid instead to an institution in which he or she is or was hospitalized, to a provider of medical, dental or vision services or supplies furnished or to be furnished to him or her, or to a person or entity that has provided or paid for, or agreed to provide or pay for, any benefits payable under the Plan. Upon receipt of such direction, the Plan Administrator or Claims Administrator, as applicable, may, solely for the convenience of a covered person, adjudicate claims received from medical providers for services rendered to covered persons and direct payment of Plan benefits to that medical provider. A direction to pay a medical provider is not a legal assignment of any benefit or right under the Plan or ERISA, or of any legal or equitable right to institute any court proceeding against the Plan, Plan fiduciaries, or the Employer. The Plan Administrator or Claims Administrator, as applicable, reserves the right to make payment directly to the covered person. No payment by the Plan Administrator or the Claims Administrator, as applicable, pursuant to such direction shall be considered an assignment of benefits or as recognition by the Plan of a duty or obligation to pay a provider of medical, dental or vision services or supplies except to the extent the Plan actually chooses to do so. Assignment may be permitted to the extent that an underlying benefit option or insurance contract specifically provides for assignment.

COORDINATION OF BENEFITS

The coordination of benefits provisions described in the Benefits Booklets delivered to you with this SPD, as interpreted by the Plan Administrator (or Insurer or Claims Administrator, if applicable) in its discretion, control all coordination of benefits situations involving the Plan and other payers.

SUBROGATION/RIGHT OF REIMBURSEMENT

When a covered person receives Plan benefits related to a certain sickness or injury, and separately recovers for such sickness or injury from a third party, including, but not limited to, tortfeasors, workers compensation programs, uninsured or underinsured motorists programs, no fault or school insurance programs, any other insurance policy or other plan of benefits, and/or any other third party, whether by insurance claims payment, lawsuit, settlement, judgment or otherwise, the covered person has to reimburse this Plan for this Plan’s benefits that they have received out of the recovery from the third party. The covered person’s receipt of benefits from this Plan means that they agree to this subrogation and reimbursement provision.

The details of the subrogation and reimbursement requirement are as follows:

General Principle: When a covered person receives Plan benefits that are also payable under workers' compensation, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, any statute, or when charges or expenses that arise through an act or omission of payment, lawsuit, settlement, judgment or for any other reason, the covered person shall reimburse this Plan for the related Plan benefits received out of any funds or monies the covered person recovers from that third party. This is the case regardless of whether the third party recovery is designated for medical costs or expenses.

Specific Requirements and Plan Rights: Because this Plan is entitled to reimbursement, this Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a covered person may have against any third party. This Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if the covered person has not been paid or fully reimbursed for all of their damages or expenses.

This Plan's share of the recovery shall not be reduced because the full damages or expenses claimed by the covered person have not been reimbursed unless the Plan agrees in writing to such reduction. Further, this Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence of any other equitable defenses that may affect this Plan's right to subrogation or reimbursement.

This Plan may enforce its subrogation or reimbursement rights by requiring the covered person to assert a claim for any recovery to which the covered person may be entitled and which relates to the received Plan benefits. This Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Plan Sponsor.

If this Plan should become aware that a covered person has received a third party payment, amount or recovery and not reported such amount, this Plan, in its sole discretion, may (i) suspend all further benefit payments related to the covered person until the reimbursable portion is returned to this Plan; (ii) offset against amounts that would otherwise be paid to or on behalf of a covered person; or (iii) terminate the covered person's coverage under the Plan.

Participants Duties and Actions: By participating in this Plan, each covered person consents and agrees that, once Plan benefits are paid, a constructive trust, lien or an equitable lien by agreement in favor of this Plan exists with regard to any payment, settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, each covered person agrees to cooperate with this Plan by reimbursing it for Plan benefits received.

Once a covered person has any reason to believe that he/she may be entitled to recovery from any third party, the covered person must notify this Plan. And, at that time, the covered person (and his/her attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of this Plan's subrogation rights and this Plan's rights to be reimbursed for expenses arising from circumstances that entitle the covered person to any payment, amount or recovery from a third party.

If a covered person fails or refuses to execute the required subrogation/reimbursement agreement, this Plan may deny payment of any benefit to the covered person until the agreement is signed. Alternatively, if a covered person fails or refuses to execute the required subrogation/reimbursement agreement and this Plan nevertheless pays benefits to or on behalf of the covered person, the covered

person's acceptance of such benefits shall constitute agreement to this Plans' right to subrogation or reimbursement, and the covered person's agreement to a constructive trust, lien and/or equitable lien by agreement in favor of this Plan on any payment, amount or recovery that the covered person recovers from any third party.

By accepting benefits under this Plan, each covered person consents and agrees that they shall not assign their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without this Plan's express written consent. As such, this Plan's reimbursement will not be reduced by attorney's fees and expenses without express written authorization from this Plan.

Any funds received by or on behalf of a covered person will be treated as being held in constructive trust on behalf of the Plan. A covered person may not receive any of the funds until the covered person has fully paid the Plan's claims for subrogation and reimbursement.

Right of Recovery

Whenever payments for a claim have been made in excess of the maximum limit for that claim under the Plan, the Plan will have the right to recover such amounts to the extent of the excess from whoever received the excess payment and/or the covered person.

INSURANCE CONTRACTS

The Employer may contract with one or more insurance companies for insured benefits to be provided under the Plan. The Employer has the right to replace any such insurance companies from time to time for any reason. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any insurance contract used to provide benefits are the property of the Employer, except to the extent, if any, that the Plan Administrator determines that a portion of the amount payable is required to be treated as an asset of the Plan. Any portion of such a payment that is required under applicable law to be treated as a Plan asset may be used to provide or pay for benefits for eligible employees or to pay reasonable Plan expenses or may be used or paid in any other manner that is consistent with applicable law regarding the use of Plan assets.

YOUR RIGHTS UNDER ERISA

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

- You can examine, free of charge, at the Plan Administrator's office and at other locations, all of the Plan documents, including insurance contracts, if any, collective bargaining agreements and copies of all documents filed by the Plan (such as detailed annual reports) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- You can obtain copies of all Plan documents governing the operation of the Plan, by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

- In some cases, the law may require the Plan Administrator to provide you with a summary of the Plan's annual financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who

operate the Plan. These people are called fiduciaries and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA. As described above, if your claim for a Plan benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial, and you have the right to obtain copies of documents relating to the decision, without charge and have the Plan review and reconsider your claim, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the preceding rights. For instance, if you make a written request for materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied after review and reconsideration by the Plan or is ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof considering the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse Plan funds, if any, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

You may have the right to continued health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this SPD and the documents governing the Plan for the rules governing your COBRA continuation coverage.

The benefits provided by the Plan constitute "minimum essential coverage" under the Affordable Care Act.

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

PROTECTIONS AGAINST DISCRIMINATION

JHU complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. JHU does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

JHU provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in alternative formats (large print, audio, accessible electronic formats, etc.).

JHU provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the JHU Office of Institutional Equity.

If you believe that JHU has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Office of Institutional Equity
Johns Hopkins University
Wyman Park Building, Suite 515
3400 North Charles Street
Baltimore, Maryland 21218
Telephone: 410-516-8075
General inquiry email: oie@jhu.edu
Disability Services and Accommodations email: oiedisability@jhu.edu
TTY: 711, MD Relay
Fax: 410-367-2665

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Office of Institutional Equity is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Rom 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019 (1-800-537-7697 TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

BENEFITS CONTACT INFORMATION

Benefit Plan Contact	Phone Number	Call For
Medical		
Wellfleet https://wellfleetinsurance.com/	877-657-5044	General Customer Service, Claims Service
Dental		
Delta Dental https://www1.deltadentalins.com/	800-932-0783	General Customer Service, Find an in-network dentist
Vision		
EyeMed www.eyemed.com	866-939-3633	General Customer Service, find an in-network provider, Claims Service
Life Insurance		
UNUM	800-235-3551	General Customer Service
Long Term Disability		
UNUM	800-235-3551	General Customer Service
Short Term Disability		
Lincoln Financial Group https://www.mylincolnportal.com (Code: JHUEE)	888-246-4483	Dedicated service line
Spending Accounts (DCFSA, HCFSA)		
Wex www.wexinc.com	866-451-3399	General Customer Service, Claims Service
Employee Assistance Program		
Employee Assistance Program https://hr.jhu.edu/benefits-worklife/support-programs/	443-997-7000	Assistance with personal problems, family issues, etc.
COBRA		
Wex www.wexinc.com	866-451-3399	Assistance with COBRA questions, General Customer Service
Health Centers		
University Health Services https://studentaffairs.jhu.edu/university-health-services	410-955-3250	To make an appointment
Student Health and Wellness Center https://studentaffairs.jhu.edu/student-health/	410-516-8270	To make an appointment

FURTHER INFORMATION

If you have further questions regarding the Plan or this SPD, please contact the university's Student Benefits Team in the Office of Benefits Services via email at JHUStudentBenefits@jhu.edu.

APPENDIX A
BENEFITS BOOKLETS

This SPD must be read in combination with the insurance contracts, certificates of coverage, evidence of coverage documents, benefit summaries and any additional documents that provide information about a benefit (together and individually referred to as "Benefits Booklets") for each of the benefit plans that are incorporated by reference into this Summary Plan Description ("SPD"). The Benefits Booklets are intended to describe the benefits available to you as a House Staff or Salaried Postdoctoral Fellow of The Johns Hopkins University, and, when read with this SPD, constitute the SPD for The Johns Hopkins University Learners' Welfare Plan and The Johns Hopkins University Learners' Cafeteria Plan (the "Plan").

Please see the Benefits Booklets for further details about Plan benefits.

For additional information or for copies of the Benefits Booklets, please contact the Plan Administrator.

Coverage	Benefits Booklets
General – All Benefits	House Staff Summary of All Benefits
Medical	Wellfleet Group LLC Schedule of Benefits
Dental	Delta Dental Schedule of Benefits
Vision	EyeMed Vision Plan Wilmer Annual Eye Exam Benefit
Life Insurance	UNUM Group Life Insurance Plan
Short-term Disability and School of Medicine Health Care and Sick Leave, Postdoctoral Trainees Policy	Lincoln Disability Policy SOM Health Care and Sick Leave Policy, Postdoctoral Trainees Policy (for House Staff and Salaried Postdoctoral Fellows enrolled in the School of Medicine)
Long Term Disability	UNUM Group Long Term Disability Plan
House Staff Supplemental Fund	House Staff Supplemental Fund
Employee Assistance Program	See JHU Human Resources Office Benefits & Worklife website for details on: Employee Assistance Program
Dependent Care / Childcare	See JHU Human Resources Office Benefits &

	Worklife website for details on: Child Care Voucher Program Backup Childcare Childcare Centers
Onsite Clinics	Student Health & Wellness Center (for Salaried Postdoctoral Fellows enrolled in the Krieger School of Arts and Sciences, Whiting School of Engineering, School of Education, and Sheridan Libraries) University Health Services (for House Staff and Salaried Postdoctoral Fellows enrolled in the School of Medicine, School of Public Health, School of Nursing, or the Berman Institute of Ethics)