



THE  
JOHNS HOPKINS  
SCHOOL OF MEDICINE  
AND  
BLOOMBERG SCHOOL  
OF PUBLIC HEALTH

STUDENT HEALTH PROGRAM  
Summary Plan Description (SPD)

# Table Of Contents

<b>Benefits for You and Your Family</b> .....	<b>1</b>
Who is Eligible.....	1
<i>Proof of Student Status</i> .....	2
When Coverage Begins.....	3
Changing Your Coverage.....	3
Special Enrollment Rights for Medical Coverage.....	4
Certificates of Coverage.....	5
<b>About Your Student Health Program</b> .....	<b>6</b>
Providers.....	6
Pre-Existing Conditions.....	6
Payment Terms You Should Know.....	7
Care Management Program.....	9
Your Student Health Program Identification Card.....	10
Customer Service.....	11
<b>Medical Benefits At-A-Glance</b> .....	<b>12</b>
<b>Student Health Program Covered Services and Supplies</b> .....	<b>16</b>
<i>In General</i> .....	16
<i>Prescription Drug Benefits</i> .....	21
<i>Emergency Services</i> .....	22
<i>Maternity Benefits</i> .....	24
<i>Women’s Health and Cancer Rights Act of 1998</i> .....	25
<i>Alternative Care</i> .....	25
<i>Home Health Care Benefits</i> .....	26
<i>Skilled Nursing Facility Benefits</i> .....	27
<i>Hospice Care Benefits</i> .....	28
<i>Surgery</i> .....	29
<i>Transplants</i> .....	29
Mental Health and Substance Abuse Services.....	30
<b>What’s Not Covered By the Student Health Program</b> .....	<b>32</b>
<b>Other Information About Your Student Health Program Benefits</b> .....	<b>38</b>
Filing A Claim.....	38
What Happens When You Have Duplicate Coverage.....	39
When the Student Health Program May Recover Payment.....	40
When Medical Coverage Ends.....	42
COBRA Continuation Coverage.....	43
When You Become Covered By Medicare.....	46

Basic Administrative Information About Your Benefits .....	47
Claims for Benefits.....	48
Protected Health Information .....	57
Your Rights Under ERISA.....	60
Student Health Program’s Rights .....	62
Plan Administrator’s Authority .....	62
For More Information.....	62

## ***BENEFITS FOR YOU AND YOUR FAMILY***

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### **Benefits for You and Your Family**

The Student Health Program offers you the security of a wide range of health care benefits, including coverage for inpatient and outpatient hospital care, medical and surgical services, prescription drugs, and mental health and substance abuse services. The Program offers you the flexibility to receive care from the physicians of your choice.

These benefits are provided under the Student Health Program and are described in this Summary Plan Description. Please read it carefully.

The medical benefits described are administered by the Johns Hopkins Employer Health Programs (EHP).

The Student Health Program has been amended effective July 1, 2006 to make certain changes. This SPD reflects the Program as amended. For periods before July 1, 2006, please refer to the July 1, 2005 version of the SPD.

### **Who is Eligible**

- Any individual holding student status (pre- or postdoctoral) in the JHU School of Medicine, Bloomberg School of Public Health, or JHH Schools of Medical Imaging;
- Any student who has registered and/or who has reached the effective date of appointment at any of the above schools.

Eligible dependents may also be covered under the Student Health Program. Eligible dependents are:

- Your legal spouse;
- Your same-sex domestic partner, as defined by the Johns Hopkins University, who is listed on your affidavit of domestic partnership;
- Your or your spouse/same-sex domestic partner's unmarried children, through the end of the calendar year in which they turn 19, who depend primarily on you for financial support and who live in your household;
- Your or your spouse/same-sex domestic partner's unmarried children from the end of the calendar year in which they turn age 19 until the end of the calendar year in which they turn 25, but only while they attend school on a full-time basis at an accredited college or university (graduate or

## ***BENEFITS FOR YOU AND YOUR FAMILY***

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undergraduate level) and they depend primarily on you for financial support. Dependent children must take the required minimum number of credits to be considered “full-time” under the school’s rules. You must provide annual proof of eligible student status as set forth below.

- Your or your spouse/same-sex domestic partner’s physically or mentally disabled dependent child (ren) of any age provided the physical or mental disability began prior to age 19. To be considered disabled, a child must be entitled to Supplemental Security Income (SSI) benefits on account of disability. However, if the child has not applied for SSI, you can instead demonstrate to the Plan Administrator’s satisfaction that the child meets the SSI disability criteria for adults -- the inability to engage in any substantial gainful activity as a result of any medically determinable physical or mental impairment(s) which can be expected to result in death, or has already lasted, or can be expected to last, for a continuous period of not less than 12 months.

Children whom you may enroll must be your natural children, stepchildren, and foster children, children legally adopted or placed for adoption, children covered by a Qualified Medical Child Support Order (QMCSO), and any children for whom you are the legal guardian.

*Please note: You may not cover a stepchild if the stepchild does not reside with you. Also, you may not cover your former spouse after the divorce has become final.*

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

If your spouse is also eligible for enrollment in the Student Health Program, he or she may choose to be covered as a participant rather than as a dependent, but not as both. Please note that your eligible dependents may only be covered by one parent’s plan.

If you have any questions about this coverage, and are enrolled through the School of Medicine, please contact the Registrar’s Office at (410) 614-3301. If you are enrolled through the Bloomberg School of Public Health, please contact the Student Accounts Office at (410) 955-5725. If you are enrolled through the JHH Schools of Medical Imaging, please call (410) 528-8208.

### ***Proof of Student Status***

You must provide proof of eligible student status. Student status verification letters will be mailed in January to employees with coverage for a child whose 20<sup>th</sup> thru 25<sup>th</sup> birthday falls in that calendar year. The letter will specify a deadline (usually February 15) by which the required proof of student status must be returned. If the required proof is returned by the deadline, student status will be considered verified through the following December 31. If the required proof is not returned by the deadline, the child’s coverage will terminate retroactively to the preceding December 31. If termination of your

## ***BENEFITS FOR YOU AND YOUR FAMILY***

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child's coverage results in a change in your membership, JHU will also change your membership election automatically.

### **Qualified Medical Child Support Order (QMCSO)**

You may enroll children who are not otherwise eligible as a dependent described above in the Student Health Program if called for by a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order setting responsibility for health care expenses for non-custodial children. If you are served with a QMCSO, please send the court order to the Registrar's Office, if you are enrolled through the School of Medicine, or, to the Student Accounts Office, if you are enrolled through the Bloomberg School of Public Health or the JHH Schools of Medical Imaging, as soon as possible. Coverage will only be provided if the Plan Administrator determines that the QMCSO meets certain requirements imposed by law.

### **When Coverage Begins**

Students are eligible to participate in the Student Health Program upon registration and/or the effective date of appointment with no waiting period. There is no coverage until you submit a properly completed application. If your completed application is received by the 10<sup>th</sup> of the month, your coverage will be effective on the first day of that month, with no waiting period. If the application is received on the 11<sup>th</sup> of the month or later, your coverage will become effective on the first day of the following month.

Medical coverage for your dependents will begin at the same time as your own if you have properly enrolled them. If you have a new baby, adopt a child, or have a child placed with you for adoption, and you enroll this dependent within 30 days, your child's coverage becomes effective on the date of the birth or adoption. If you marry and you enroll your spouse within 30 days after your marriage, your spouse's coverage becomes effective on the date of your marriage or you have the option to begin your coverage no later than the first of the month following the date of marriage.

### **Changing Your Coverage**

During the annual enrollment period, you may change your Student Health Program coverage. Outside of the annual enrollment period, you may change coverage *only* if you have a qualifying family status change or a special enrollment situation (see heading **Special Enrollment Rights**). Appropriate documentation of the life event may be required.

Examples of IRS-qualified changes in family status include:

- ◆ Marriage, legal separation, annulment, or divorce;

## ***BENEFITS FOR YOU AND YOUR FAMILY***

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- ◆ Birth, death, or adoption of a dependent;
- ◆ Placement for adoption of a dependent;
- ◆ Your dependent becomes eligible or is no longer eligible for coverage under the Student Health Program;
- ◆ You are required to cover your child due to a QMCSO;
- ◆ You or your dependent become eligible for Medicare or Medicaid (you may change the current election for the eligible person only); and
- ◆ Any other event that qualifies as a family status change under the Internal Revenue Code (with the approval of the Plan Administrator) to be consistent with your family status change.

Further, any student, their spouse, or dependent child whose coverage under any other group health plan ends is permitted to enroll in coverage under the Program within 30 days of the date of the loss of other coverage as explained below under Special Enrollment Rights. Please notify the Registrar's Office, School of Medicine, Student Accounts Office, Bloomberg School of Public Health, or the JHH Schools of Medical Imaging about your situation to see if coverage is available.

Any change in your benefit enrollment must correspond directly to the change in family status. If you submit a new enrollment form or a change of information form within 30 days after the change, coverage becomes effective on the date of the change. If you delay past 30 days, you must wait until the next open enrollment before coverage can become effective. Please keep the Johns Hopkins University School of Medicine, Bloomberg School of Public Health Student Health Program and JHH Schools of Medical Imaging informed of any changes in family status by contacting the appropriate school.

### **Special Enrollment Rights for Medical Coverage**

#### ***Losing other coverage***

If you did not enroll in the Student Health Program because you had coverage through another source (such as a spouse's employer or COBRA), and you subsequently lose that coverage, you may enroll for medical coverage under the Student Health Program. You must request this ***special enrollment*** by submitting a properly completed enrollment form within 30 days of losing your other coverage. Student Health Program medical coverage will become effective on the date after you lost the other coverage, provided you enroll within 30 days.

## ***BENEFITS FOR YOU AND YOUR FAMILY***

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

### ***New Dependents***

Dependents whom you acquire through marriage, birth, adoption, or placement for adoption, may be granted a ***special enrollment***, as long as you have requested coverage by submitting a properly completed enrollment form within 30 days following the date you acquired the dependent. You must go to the Registrar's Office, School of Medicine, the Student Accounts Office, Bloomberg School of Public Health, or the JHH Schools of Medical Imaging to request special enrollment. In the case of marriage, medical coverage will become effective on the date of your marriage, or you have the option to begin your coverage no later than the first of the month following the date of marriage. In the case of birth, adoption, or placement for adoption, coverage will become effective on the date of the event. In either case, you must enroll within 30 days after the event. If you do not have coverage for yourself or your spouse, you may also enroll yourself or your spouse when you enroll your new dependent.

### **Certificates of Coverage**

If you or a covered dependent lose your Student Health Program coverage (including COBRA coverage), be sure to notify the School of Medicine, the Bloomberg School of Public Health or the JHH Schools of Medical Imaging and request a certificate of coverage. This certificate of coverage is available at no cost to you. At a minimum, this certificate will state the length of time you (or your covered dependent) had uninterrupted medical coverage. It will also show the date coverage ended. The certificate of coverage may allow you to reduce any pre-existing condition limits that apply to future medical coverage.

Please note that certificates are not automatically provided for dependents until the appropriate school is aware that the dependent has lost coverage (for example, when a dependent no longer qualifies for coverage because of age).

You may request a certificate of coverage for up to 24 months from the date your coverage ended.

## ***ABOUT YOUR STUDENT HEALTH PROGRAM***

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### **About Your Student Health Program**

The Student Health Program benefits described in this SPD are administered by Johns Hopkins Employer Health Programs.

#### **Providers**

For the purposes of this Program, a provider is any hospital, skilled nursing facility, individual, organization, or agency licensed to provide professional services and acting within the scope of that license or certification. Benefits will only be paid for covered services from providers who meet this definition.

The Student Health Program allows you to go to any provider in the Johns Hopkins Employer Health Programs network, or you may go to a provider that is not in the network. The choice is yours. However, as explained below, the Program only covers charges up to the Reasonable and Customary Charge (R&C Charge). A network provider will never charge you more than the Reasonable and Customary Charge. However, a non-network provider can charge you more than the Reasonable and Customary Charge, and you must pay the difference.

You should ask your provider if they are in the EHP network before you receive services. For a complete listing of EHP network providers, please see the provider directory available at [www.ehp.org](http://www.ehp.org), or by calling 410-424-4485.

*Please note:* Benefits will not be provided under the Student Health Program for any services and related charges provided by an immediate relative of the patient (spouse, same-sex domestic partner, child, grandchild, brother, sister, in-law, grandparent, or parent).

#### **Pre-Existing Conditions**

Your coverage under the Student Health Program is affected by any pre-existing condition you may have before becoming eligible for coverage. A pre-existing condition is any physical or mental condition for which you or your eligible dependents have been diagnosed or received treatment, including any medical services or medication, during the 90 days before the effective date of your coverage.

If you have one or more pre-existing conditions, any charges incurred during the first 365 days of coverage to treat this condition(s) will be subject to a \$10,000 maximum.

*Please note:* The exclusion will apply for a period of 365 consecutive days beginning on the covered person's enrollment date. However, if you were previously covered by another health plan, the period of time for which you were covered may be credited against the 365-day exclusion period. You will

## ***ABOUT YOUR STUDENT HEALTH PROGRAM***

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need to submit a certificate of creditable coverage from your prior health plan to the Registrar's Office, School of Medicine, Student Accounts Office, Bloomberg School of Public Health, or the JHH Schools of Medical Imaging. Contact your respective school if you have any questions or if you need help in obtaining a certificate of creditable coverage from your prior plan. Prior health plan coverage is only recognized if there is no more than a 62-day gap between your coverage under the prior plan and your Student Health Program coverage.

The \$10,000 maximum does not apply to charges related to pregnancy. It also does not apply to a newborn child, adopted child, or child placed for adoption provided that the child is enrolled in the Student Health Program or another health plan within 30 days of the date of birth, adoption or placement for adoption. The prohibition against applying the maximum to a newborn child, adopted child, or child placed for adoption does not apply to the child after the end of a period of 63 consecutive days during which the child is not covered under the Program or any other health plan coverage.

### **Payment Terms You Should Know**

To help you understand how your benefits are processed and paid, please refer to the following terms.

- ◆ **Deductible and deductible carryover feature** — The deductible is the amount you must pay each calendar year before the Student Health Program begins to pay benefits. Expenses incurred and applied to your deductible in October, November, and December of a calendar year are also carried over and applied to the next calendar year's deductible. Expenses incurred by three or more individuals can meet the family deductible. However, no one individual will be required to satisfy more than the individual deductible. If you transfer from one student status to a different status that is still eligible for coverage under the Program, and you do not have any lapse of coverage, any amounts you paid towards a year's deductible will still be counted and the deductible carryover feature will continue to apply. Please note that your coinsurance payments (i.e., your percentage or share of expenses) and any amounts over the Reasonable and Customary Charge do not apply toward the deductible.

If two or more family members receive injuries in the same accident, and, as a result of those injuries, incur covered expenses, only one deductible amount will be deducted from the total covered expenses incurred as a result of those injuries. If you acquire two or more children as a result of a multiple birth and if you incur covered expenses for those children as a result of premature birth, abnormal congenital condition, or sickness commencing or injury received not more than 30 days after their birth, only one deductible amount will be deducted from the total covered expenses incurred for those children as a result of the multiple birth.

## ***ABOUT YOUR STUDENT HEALTH PROGRAM***

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- ◆ Cost Sharing Provision — The term *coinsurance* describes the way that you share in the cost of your medical expenses.
  - ***Coinsurance:*** The coinsurance is your share for certain medical expenses. After the deductible is satisfied, the Program generally pays 80% of the Reasonable and Customary Charge for most services and you pay the remaining 20%, plus any amounts over the Reasonable and Customary Charge.
  - ***Out-of-Pocket Maximum:*** Since you are responsible for a portion of the cost of your medical expenses, the Program includes an annual out-of-pocket maximum to protect you in the event of high medical bills. After you have paid the annual out-of-pocket maximum (\$3,000 per person or \$9,000 per family), the Program covers any additional medical expenses incurred in the same calendar year at 100%. The out-of-pocket maximum applies on a per person basis, regardless of your level coverage (individual, husband and wife, family, etc.). For example, if you have individual coverage, your maximum is \$3,000. If you have family coverage, your maximum and the separate maximum for each member of your family is still \$3,000. Plus, once you have paid \$9,000 during a year for all members of your family in total, then all members of your family have met the maximum.

The out-of-pocket maximum includes the deductible and coinsurance but does not include: penalties; prescription drug coinsurance and expenses; Program maximums; any charges for services which are not covered; any charges above the Reasonable and Customary Charge, or mental health and substance abuse charges.

- ◆ Maximum Benefit — This is the maximum amount the Student Health Program will pay for a covered individual during his or her lifetime. The lifetime benefit maximum for this Program is \$1,000,000. The lifetime benefit maximum includes a lifetime maximum of \$250,000 for substance abuse care, including drugs and medicines prescribed for chemical dependency care. (Certain other limits may apply for specific treatments as described elsewhere in this SPD.)
- ◆ Reasonable and Customary Charge (R&C) — This is the usual fee charged by similar providers for the same services or supplies in the same geographic area. Johns Hopkins Employer Health Programs determines what is a Reasonable and Customary Charge. The Student Health Program only covers charges up to the Reasonable and Customary Charge. An EHP network provider will never charge you more than the Reasonable and Customary Charge. However, a non-network provider can charge you more than the Reasonable and Customary Charge, and you must pay the difference.

## ***ABOUT YOUR STUDENT HEALTH PROGRAM***

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### **Care Management Program**

The Student Health Program has several features designed to help both you and the Program manage health care costs, while still providing you with quality care. While part of increasing health care costs results from new technology and important medical advances, another significant cause is the way health care services are used.

Some studies indicate that a high percentage of the cost for health care services may be unnecessary. For example, hospital stays can be longer than necessary. Some hospitalization may be entirely avoidable, such as when surgery could be performed at an outpatient facility with equal quality and safety. Also, surgery is sometimes performed when other treatment could be more effective. All of these instances increase costs for the Student Health Program and you. To help control these costs, the Program features a Care Management Program.

Before you can receive benefits for certain medical services or supplies under the Program, you must have them pre-certified and coordinated through the Care Management Program. You must initiate the pre-certification process by contacting your Student Health Program Customer Service representative at (888) 400-0091 or (410) 424-4485. If you do not obtain pre-certification, coverage for the services or supplies may be limited or denied. The following services and supplies require pre-certification through the Care Management Program:

- ◆ Acupuncture;
- ◆ Durable medical equipment and medical supplies;
- ◆ Home health care;
- ◆ Hospice care;
- ◆ Hospital stays;
- ◆ Inpatient rehabilitation services;
- ◆ Outpatient surgical center facility charges;
- ◆ Prosthetic devices and orthotics;
- ◆ Skilled nursing facility stays;

## ***ABOUT YOUR STUDENT HEALTH PROGRAM***

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- ◆ Speech therapy;
- ◆ Surgical procedures (certain procedures only, as described on a list maintained by Johns Hopkins EHP on behalf of the Student Health Program). You are required to contact Student Health Program Customer Service to see if a procedure is on the list. If it is, it is your responsibility to obtain pre-certification;
- ◆ Transplant services; and
- ◆ Use of certain drugs, supplies, and medications (certain drugs and medications only, as described on a list maintained by Johns Hopkins EHP on behalf of the Student Health Program). You are required to contact Student Health Program Customer Service to see if a drug, supply, or medication is on the list. If it is, it is your responsibility to obtain pre-certification.

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

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

You must initiate the pre-certification process by contacting your Student Health Program Customer Service representative at (888) 400-0091 or (410) 424-4485.

### **Your Student Health Program Identification Card**

A Student Health Program identification card will be issued to you and each of your covered dependents. Carry your identification card with you at all times and show it to any health care provider whenever you receive medical care.

Only you and your covered dependents are permitted to use the identification card. It is illegal to loan your card to persons who are not covered under the Program. If you lose your identification card, call your Student Health Program Customer Service Representative or the enrollment office in your respective school immediately to request a new card.

## ***ABOUT YOUR STUDENT HEALTH PROGRAM***

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Your identification card includes important information and phone numbers.

### **Customer Service**

An important feature of your Student Health Program is the Customer Service Representatives available to serve you. Trained Customer Service Representatives are available to assist you by answering any questions you may have about covered benefits, using your program, filing a claim, resolving complaints, etc.

If you have a question, Customer Service Representatives are available Monday through Friday, from 8 a.m. to 5 p.m., at (888) 400-0091 or (410) 424-4485.

## ***MEDICAL BENEFITS AT-A-GLANCE***

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### **Medical Benefits At-A-Glance**

The following chart summarizes most of the benefits and services available under the Student Health Program.

<b><i>Services and Supplies</i></b>	<b><i>Student Health Program</i></b>
<b>Treatment of Illness or Injury</b>	
Primary care office visit	80% of R&C, after deductible
Specialty care office visit	80% of R&C, after deductible
Diagnostic services and treatment	100% of R&C
<b>Preventive Services</b>	
General physical exam	Not covered
Diagnostic services for physical exam	Not covered
Well-Child care: office visits, flu vaccines, immunizations and PKU, urinalysis and lead testing	100% of R&C
Mammograms (screening) (age 35 with family history OR age 40)	100% of R&C once per 12 month period
Colonoscopy screening	80% of R&C, after deductible
Annual GYN exam	Not covered
Adult immunizations and inoculations	Not covered
<b>Surgical Procedures</b>	
Professional services for inpatient and outpatient surgery	80% of R&C, after deductible <sup>(1)</sup>
Reconstructive and/or surgically implanted prosthetics	80% of R&C, after deductible <sup>(1)</sup>

(1) Failure to obtain pre-certification will result in a denial of benefits.

“R&C” (Reasonable and Customary Charge) is explained under the heading “Payment Terms You Should Know”, earlier in this SPD. You are responsible for any charges above R&C.

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

## ***MEDICAL BENEFITS AT-A-GLANCE***

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<b><i>Services and Supplies</i></b>	<b><i>Student Health Program</i></b>
<b>Medical Supplies</b>	
Disposable supplies (e.g. ostomy bags, diabetic supplies, syringes, etc.)	80% of R&C, after deductible
<b>Laboratory and X-Ray Procedures</b>	
Laboratory tests, imaging exams, X-rays and ultrasound	100% of R&C
<b>Reproductive Health</b>	
Physician office visits (for prenatal care only)	80% of R&C, after deductible
Full care for the mother during pregnancy	
Physician care	80% of R&C, after deductible <sup>(1)</sup>
Hospitalization	100% of R&C for 1 <sup>st</sup> 30 days, then 80% of R&C, after deductible <sup>(2)</sup>
Laboratory and X-ray services	100% of R&C
Birthing center (licensed facility only)	100% of R&C <sup>(1)</sup>
Voluntary sterilization	80% of R&C, after deductible <sup>(1)</sup>
<b>Allergy Tests and Procedures</b>	
Allergy tests	100% of R&C
Desensitization materials and serum	80% of R&C, after deductible
<b>Urgent Care Center</b>	
Physician visit	80% of R&C, after deductible
Diagnostic services and treatment	100% of R&C
<b>Emergency Services</b>	
Emergency care for accident or illness (i.e. the onset of a sudden and serious condition requiring immediate care) facility and professional fees	100% of R&C for services within 72 hours after onset of emergency, otherwise, 80% of R&C, after deductible
<b>Hospital Care</b>	
Inpatient care (semi-private, unless private room is medically necessary)	100% of R&C for 1 <sup>st</sup> 30 days, then 80% of R&C, after deductible <sup>(1)</sup>
Intensive care	100% of R&C for 1 <sup>st</sup> 30 days then 80% of R&C, after deductible <sup>(1)</sup>
Other inpatient services	100% of R&C for 1 <sup>st</sup> 30 days, then 80% of R&C, after deductible <sup>(1)</sup>

(1) Failure to obtain pre-certification will result in a denial of benefits.

(2) Hospitalization must be precertified for more than 48 hours after delivery (96 hours if caesarean).

“R&C” (Reasonable and Customary Charge) is explained under the heading “Payment Terms You Should Know”, earlier in this SPD. You are responsible for any charges above R&C.

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

## ***MEDICAL BENEFITS AT-A-GLANCE***

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<b><i>Services and Supplies</i></b>	<b><i>Student Health Program</i></b>
Inpatient physician services (excluding surgical services)	80% of R&C, after deductible <sup>(1)</sup>
Hospital inpatient days limitation	No limit for medically necessary days; <i>(Limits apply for Substance Abuse treatment)</i>
Skilled Nursing/Rehabilitation facility	100% of R&C for 1 <sup>st</sup> 30 days, then 80% of R&C, after deductible <sup>(1)</sup>
Outpatient services, including outpatient testing prior to outpatient surgery	100% of R&C
Outpatient surgery facility charges, including freestanding surgical centers	100% of R&C <sup>(1)</sup>
<b>Chemotherapy/Radiation Therapy</b>	
Physician services and materials	80% of R&C, after deductible
<b>Acupuncture</b>	
\$300 maximum per calendar year	80% of R&C, after deductible <sup>(1)</sup>
<b>Home Health Care</b>	
Must be provided by a licensed health care organization	100% of R&C for 90 visits per calendar year <sup>(1)</sup>
<b>Hospice Care</b>	
Inpatient and home	100% of R&C <sup>(1)</sup>
<b>Ambulance Transportation</b>	
To and/or from a hospital only	80% of R&C, after deductible
<b>Speech Therapy</b>	
Restorative, non-developmental therapy only	80% of R&C, after deductible <sup>(1)</sup>
<b>Physical/Occupational Therapy</b>	
Excludes maintenance therapy	80% of R&C, after deductible
<b>Chiropractic Care</b>	
Restricted to initial evaluation, X-Rays and spinal manipulations limited to \$1,000 calendar year maximum	80% of R&C, after deductible;
<b>Durable Medical Equipment</b>	
Equipment, prosthetic appliances, and medical supplies	80% of R&C, after deductible <sup>(1)</sup>
<b>Mental Health and Substance Abuse Services</b>	
Professional fees for inpatient mental health care	80% of R&C after deductible
Facility charges for inpatient mental health care	100% of R&C for 30 days per calendar year then 80% of R&C, after deductible <sup>(1)(2)</sup>

(1) Failure to obtain pre-certification will result in a denial of benefits.

(2) Two partial hospitalization days equal one inpatient hospital day and are paid according to the inpatient benefit level.

“R&C” (Reasonable and Customary Charge) is explained under the heading “Payment Terms You Should Know”, earlier in this SPD. You are responsible for any charges above R&C.

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

## ***MEDICAL BENEFITS AT-A-GLANCE***

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<b><i>Services and Supplies</i></b>	<b><i>Student Health Program</i></b>
Professional fees for outpatient mental health care	52% of R&C, after the deductible for 1 <sup>st</sup> 20 visits per calendar year, then 50% of R&C, after deductible
Facility charges for inpatient substance abuse care	Detoxification: 100% of R&C for 7 days per calendar year, then 80% of R&C, after deductible; <sup>(1)(2)</sup> Rehabilitation: 100% of R&C for 30 days per calendar year, then 80% of R&C, after deductible <sup>(1)(2)</sup>
Professional fees for inpatient and outpatient substance abuse care	80% of R&C, after deductible
Facility charges for outpatient substance abuse care	100% of R&C, up to 30 visits per calendar year maximum
<b>Prescription Drugs</b>	
Retail pharmacy: 34-day supply	80% of R&C
Mail order: 90-day supply	80% of R&C
<b>Maximum Lifetime Benefit Per Person</b>	\$1,000,000
<b>Maximum Lifetime Benefit Per Person For Substance Abuse Care</b>	\$250,000; 120 days/visits combined for all inpatient and outpatient care
<b>Calendar Year Deductible</b>	
Individual	\$100
Family	\$300
<b>Coinsurance Out-of-Pocket Maximum Per Calendar Year (Including Deductible)</b>	
Individual	\$3,000
Family	\$9,000

(1) Failure to obtain pre-certification will result in a denial of benefits.

(2) Two partial hospitalization days equal one inpatient hospital day and are paid according to the inpatient benefit level.

“R&C” (Reasonable and Customary Charge) is explained under the heading “Payment Terms You Should Know”, earlier in this SPD. You are responsible for any charges above R&C.

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

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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### **Student Health Program Covered Services and Supplies**

The Student Health Program provides benefits for the services and supplies listed in this section. Only services and supplies that are medically necessary are covered.

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

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

In the case of an inpatient admission, medically necessary also means treatment that could not adequately be provided on an outpatient basis.

Benefit maximums and coinsurance amounts are described in detail in the **Medical Benefits At-A-Glance** chart. The chart highlights the major benefits that will be payable for your care.

#### ***In General***

Covered services and supplies include the following (when medically necessary and subject to any conditions or limitations as described elsewhere in this SPD):

- ◆ Abortion (elective);
- ◆ Acupuncture (for anesthesia, pain control or therapeutic purposes provided by a licensed acupuncturist), up to \$300 per person per calendar year;
- ◆ Ambulance service (professional), to the nearest hospital where necessary care can be given if the emergency is life threatening;

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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- ◆ Ambulatory surgical center;
- ◆ Anesthetics and oxygen, and their administration;
- ◆ Benefits for covered foreign nationals holding J visas:
  - Expenses for repatriation of remains up to \$7,500;
  - Expenses associated with the medical evacuation of the exchange visitor to his or her home country up to \$10,000;
- ◆ Birthing facilities, provided the physician in charge is acting within the scope of his or her license and the birthing facility is a freestanding licensed facility for childbirth which meets state licensing requirements;
- ◆ Blood products, if not replaced;
- ◆ Casts, splints;
- ◆ Chiropractic care for spinal manipulation, misalignment or partial dislocation of or in the vertebral column and correction by manual or mechanical means of nerve interference. Only initial consultation, x-rays and spinal manipulations are covered, up to a \$1,000 calendar year maximum.
- ◆ Charges for the treatment of cleft lip and cleft palate conditions. These include expenses for oral surgery, otologic, audio logical and speech/language treatment;
- ◆ Cosmetic surgery, but only if needed:
  - Due to accidental injury or illness (unless the Program would exclude coverage for the injury or illness for a reason other than it occurred before coverage began), or
  - Because of impaired bodily function or deformity resulting from disease, trauma, congenital or developmental anomalies, or previous therapeutic processes;
- ◆ Dental services if rendered as initial treatment as a result of accidental injury to the jaws, sound natural teeth, mouth, or face, provided care commences within 72 hours of the accident. Injury as a result of chewing or biting shall not be considered an accidental injury. In circumstances where oral surgery or dental treatment are otherwise covered, inpatient facility charges for services that ordinarily could be performed in the provider's office will be covered only if the patient has a concurrent medical condition that prohibits doing the treatment safely in the provider's office. The

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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Program will pay surgical benefits for cutting procedures for the treatment of diseases, injuries, fractures and dislocations of the jaw when the service is performed by a physician or dentist. Normal extraction and care of teeth and structures directly supporting the teeth are not included;

- ◆ Diabetic supplies for insulin dependent diabetics;
- ◆ Diagnostic medical procedures; including colonoscopy screening, EKG, EEG, and other electronic diagnostic medical procedures;
- ◆ Doctors' (including surgeons') fees for treatment of illness or injury;
- ◆ Doctors' fees and hospital charges for maternity care;
- ◆ Doctors' fees for office visits;
- ◆ Drugs and medicines, including those for the treatment of psychiatric illness or chemical dependency, requiring a written prescription order and which are approved for general use by the Food and Drug Administration, and prescribed insulin and syringes used by a diabetic. Such drugs and medicines must be dispensed by a licensed pharmacist;
- ◆ Durable medical equipment (rental or purchase), including wheelchairs. If purchased, charges for repair or medically necessary replacement of Durable Medical Equipment will be considered a covered expense. Durable medical equipment is medical equipment which:
  - Can withstand repeated use; and
  - Is primarily and customarily used to serve a medical purpose; and
  - Is generally not useful to a person in the absence of illness or injury; and
  - Is appropriate for use in the home; and
  - Is not primarily for the convenience of the patient;
- ◆ Emergency services;
- ◆ Foot care for incision and drainage of infected tissues of the foot, removal of lesions, cutting of infected toenails, treatment of fractures and dislocations of bone in the foot;
- ◆ Foot orthotics that are an integral part of a leg brace and the cost is included in the orthotist's charge, or they are custom-molded and related to a specific medical diagnosis; orthopedic shoes (not integral to a brace) and supportive devices for the feet are not covered;

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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- ◆ Freestanding dialysis facility;
- ◆ Home health care;
- ◆ Hospice care;
- ◆ Hospital charges for covered semi-private room and board and other hospital-provided services and supplies. Benefits are paid at 100% of Reasonable and Customary Charges for the first 30 days of inpatient care, and 80% of Reasonable and Customary Charges, after the deductible, thereafter. These 30 days include all covered inpatient days;
- ◆ Inpatient consultation services for a specialist in the medical field for which the consultation relates, when rendered in a covered facility at the request of the attending professional provider. The Program will pay for one such consultation, limited to three consultations during any one inpatient stay. Staff consultation required by the facility is not covered;
- ◆ Laboratory tests;
- ◆ Mammogram screening (once per 12 months) for women age 40 and older, or age 35 and older with a family history of breast cancer;
- ◆ Mental health and substance abuse benefits;
- ◆ Midwife delivery services, provided that the state in which such services are performed has a licensing or certification process for midwifery, and the midwife is licensed at the time delivery is performed;
- ◆ Newborn care;
- ◆ Nursing services (professional) in your home by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who is not an immediate relative of the patient (spouse, same-sex domestic partner, child, grandchild, brother, sister, in-law, grandparent, or parent) and who does not ordinarily live with the patient;
- ◆ Pre-admission testing;

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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- ◆ Prosthetic devices, such as artificial limbs and eyes, and orthotics that are integral to the device, including charges for repair or medically necessary replacement;
- ◆ Rehabilitation facility services;
- ◆ Second surgical opinions—must be rendered by a board-certified specialist in the treatment of your particular medical condition, who is not associated professionally or financially with the physician that provided the first surgical opinion consultation. One additional consultation, as a third opinion, is covered in cases where the second opinion disagrees with the first. To avoid unnecessary duplicate testing, you should provide the specialists rendering the surgical opinions with any test results from the doctor who initially recommended surgery;
- ◆ Skilled nursing facility services;
- ◆ Support garments;
- ◆ Surgical dressings and medical supplies when ordered by an appropriate professional provider in connection with medical treatment (excluding self-administered supplies or convenience items);
- ◆ Surgical procedures;
- ◆ Treatment of Temporomandibular Joint Syndrome (TMJ) and/or myofascial pain, limited to physical therapy, surgery and ortho devices such as mouthguards and intraoral devices (excluding orthodontics and prosthetics); treatment to alter vertical dimension are covered when treatment plan is submitted and approved in advance by Care Management Program;
- ◆ Therapies, including:
  - Chemotherapy (inpatient and outpatient)—the treatment of malignant disease by chemical or biological antineoplastic agents, including the cost of the antineoplastic;
  - Dialysis treatment—the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, to include hemodialysis or peritoneal dialysis;
  - Physical therapy—the treatment by physical means, hydrotherapy, heat, or similar modalities; physical agents; bio-mechanical and neuro-physical principles; and devices to significantly relieve pain, restore maximum function lost or impaired by disease or accidental injury, and prevent disability following disease, injury or loss of body part (does not include maintenance therapy). These services must be provided by a licensed physical therapist;

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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- Occupational therapy—the treatment of a physically disabled person by means of constructive activities designed and adapted to significantly improving the functional restoration of the person’s abilities lost or impaired by disease or accidental injury, to satisfactorily accomplish the ordinary tasks of daily living in the home setting (does not include maintenance therapy);
  - Radiotherapy (inpatient and outpatient)—the treatment of disease by x-ray, gamma ray, accelerated particles, measons, neutrons, radium or radioactive isotopes;
  - Respiration therapy—the introduction of dry or moist gases into the lungs for treatment purposes;
  - Speech therapy—the treatment for the correction of a speech impairment when therapy is aimed at restoring the level of speech the individual had attained before the onset of a condition. Speech therapy for developmental disorders, such as stuttering, articulation disorders, tongue thrust, lisping, etc. is not covered;
- 
- ◆ Transplants;
  - ◆ Vasectomies and tubal ligations;
  - ◆ Well-child care; and
  - ◆ X-ray, radium, and radioisotope treatment.

Following are descriptions of other services and supplies that are covered by the Student Health Program when medically necessary.

### ***Prescription Drug Benefits***

Benefits are paid for prescription drugs designated as such under federal law, as well as injectable insulin, diabetic supplies (needles and syringes), and other medicines and supplies designated by Johns Hopkins EHP on behalf of the Student Health Program. You can receive a supply of up to 34 days or 100 units, whichever is greater. The Program pays 80% of the Reasonable and Customary Charge for each separate prescription or refill for a generic or brand name drug. You pay the remaining 20%, plus any amounts over the Reasonable and Customary Charge. A 90-day supply is available through the mail order prescription program for maintenance prescriptions. Participating pharmacy directories and mail order forms are available at the School of Medicine Registrar’s Office, the Student Accounts Office at the Bloomberg School of Public Health, or the JHH Schools of Medical Imaging.

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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Prescribed oral contraceptives and contraceptive devices are covered, however non-prescribed contraceptives and devices are not covered. Removal of Norplant is covered; however insertion of Norplant is not covered.

Your prescription drug benefits cover erectile dysfunction drugs, provided:

- ◆ The member is male;
- ◆ There is a documented organic cause of erectile dysfunction;
- ◆ The maximum monthly number of doses is limited to six with refills limited to three months per prescription.

### **What's Not Covered**

No prescription drug benefits will be paid for the following:

- Any amounts you are required to pay directly to the pharmacy for each prescription or refill;
- Charges for a prescribed drug or medication that is not approved by the FDA for treatment of the condition;
- Non-prescribed oral contraceptives, contraceptive devices or methods;
- Insertion of Norplant;
- Any charge for *administration* of drugs or insulin;
- Any drugs that are not prescribed for the treatment of an illness or injury. For example, the Program does not cover vitamins, Psoralens, Tretonin, anorexants or diet pills, Methadone, or Minoxidil;
- Any drug or medication that is available over-the-counter, except as described in this SPD. A drug or medication is considered to be available over-the-counter if it can legally be purchased without a prescription, even if your doctor gives you a prescription for it;
- Any drug or medication that is used for treatment of a condition for which coverage is otherwise excluded as described elsewhere in this SPD. For example, this means that drugs or medications for artificial reproduction treatment, such as in vitro fertilization, are not covered.

Please note: Prescriptions are not covered under the Program if written by a member of the Student Health Program. Prescriptions are also not covered if written by an immediate relative of the patient (spouse, same-sex domestic partner, child, grandchild, brother, sister, in-law, grandparent, or parent) or by someone who ordinarily lives with the patient.

### ***Emergency Services***

It is not easy to think clearly in a medical emergency. Knowing what to do before you are faced with an emergency can help you get appropriate care at the higher benefit level.

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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In an emergency medical situation, you should go to the nearest medical facility for immediate treatment. An “emergency medical situation” is one in which a prudent lay person would determine that:

- ◆ Immediate care is needed as the result of a sudden and serious illness or injury; and
- ◆ Care is required to prevent:
  - permanently placing the patient’s health in danger;
  - causing other serious medical consequences;
  - causing serious impairment to bodily functions; or
  - causing serious permanent dysfunction of any bodily organ or part.

You do not need to obtain pre-certification under the Care Management Program for treatment of an emergency medical situation. However, you (or someone on your behalf) must notify Student Health Program Customer Service at 410-424-4485 or 800-261-2393 within 48 hours after you go to an emergency room or the emergency room visit will not be covered. In all cases, if you receive treatment in an emergency room for a condition that is not an emergency medical situation, the Program will not cover the emergency room visit.

Treatment of an emergency medical situation is covered at 100% of the Reasonable and Customary Charge for treatment received within 72 hours after the onset of the emergency (whether due to an illness or an accident). Otherwise, treatment of an emergency medical situation is covered at 80% of the Reasonable and Customary Charge, after the deductible.

Treatment of an emergency medical situation does not include admission to the hospital for inpatient services. For any treatment other than treatment of an emergency medical situation, you must determine if the treatment is subject to the pre-certification requirements of the Care Management Program. If pre-certification is required, you must initiate the pre-certification process, even if the treatment is for Urgent Care. (See the discussion of Urgent Care Claims earlier in this SPD.)

### **Urgent Care Centers**

If your regular provider is unable to see you and believes you need prompt medical attention for a condition which is not serious enough to be an “emergency medical situation” as described above, he or she may refer you to an urgent care center. An urgent care center is a facility licensed to provide medical services for unexpected illnesses or injuries that require prompt medical attention, but are not life- or limb-threatening. Physician visits at an urgent care center are covered at 80% of the Reasonable and Customary Charge, after the deductible. Diagnostic services and treatment are covered at 100% of the Reasonable and Customary Charge, with no deductible.

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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*Please Note:* An “urgent care center” is a name used to describe a facility that treats medical conditions that are not serious enough to require going to an emergency room. A patient’s condition does not have to meet the definition of “Urgent Care” set forth above in order for the patient to go to an urgent care center.

### **Ambulance Services**

Your Student Health Program includes coverage for both air and ground professional ambulance transportation services, when the following criteria are met:

- ◆ Because of an accident or emergency medical situation, it is medically necessary to transport you to the hospital; or
- ◆ It is medically necessary to transport you from a hospital as an inpatient to another hospital, because:
  - The first hospital lacks the equipment or expertise necessary to care for you;
  - You are transported directly from a hospital to a skilled nursing facility or rehabilitation facility; or
  - As otherwise specifically approved by the Care Management Program.

Air ambulance is only covered if it is medically necessary to be transported by air instead of by ground.

### ***Maternity Benefits***

Even if you were not enrolled in the Medical Plan before your first pre-natal visit, you may still receive benefits during your pregnancy and delivery.

The Student Health Program covers your prenatal care and delivery at 80% of the Reasonable and Customary Charge, after the deductible, and at 100% of the Reasonable and Customary Charge for routine tests. Hospital or birthing center expenses are treated just like any other covered hospital stay. Midwife delivery services provided by a licensed midwife are also eligible. If you are an expectant mother, call Student Health Program Customer Service at least eight weeks before your due date and call again after you have been admitted to the hospital for delivery.

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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The Student Health Program will provide maternity benefits for a mother and a covered newborn child for hospital stays up to:

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

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

Please note that no benefits are provided for the newborn child unless the child is properly enrolled in the Student Health Program within 30 days after birth. See the discussion of *New Dependents* on page 4 for more information.

### ***Women's Health and Cancer Rights Act of 1998***

The Student Health Program provides benefits for participants electing breast reconstruction in connection with a mastectomy. These include:

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

The manner of coverage is determined in consultation with the attending physician and patient. Normal deductibles, coinsurance, and any annual or lifetime maximums will apply.

### ***Alternative Care***

Sometimes, following a serious illness or major surgery, you may need follow-up care. Generally, this care does not need to be provided in a hospital. Alternative care includes home health care and/or skilled nursing care. In the case of a terminal illness, hospice care is often a viable alternative to a hospital setting. The Student Health Program pays benefits toward a variety of these alternative care services.

# ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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## ***Home Health Care Benefits***

*Please note: All home health care benefits must be pre-certified under the Care Management Program described earlier in this SPD.*

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

The following services and supplies must be provided by a licensed health care organization to be covered. No benefits are paid for services performed by an immediate relative of the patient (spouse, same-sex domestic partner, child, grandchild, brother, sister, in-law, grandparent, or parent) or by someone who ordinarily lives with the patient. Please note that a home health care visit is limited to four hours. *No more than 90 visits in total, including not more than 40 home health aide visits, are covered per calendar year.*

Covered home health care services include:

- ◆ Part-time or intermittent skilled nursing care by a nurse;
- ◆ Part-time or intermittent home health aide services for a patient who is receiving covered nursing or therapy services;
- ◆ Physical, respiratory, occupational, and speech therapy when provided by a home health care agency;
- ◆ Medical and surgical supplies when provided by a home health care agency (excluding prescription drugs);
- ◆ Oxygen and its administration; and
- ◆ Medical and social service consultations.

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

- ◆ Domestic or housekeeping services;
- ◆ Dietician services;
- ◆ Dialysis treatment;
- ◆ Maintenance therapy;
- ◆ Rental or purchase of equipment or supplies;
- ◆ Meals-on-wheels or other similar food arrangements;
- ◆ Home care provided in a nursing home or skilled nursing facility (see ***Skilled Nursing Facility Benefits***, discussed below);

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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- ◆ Home care for mental health conditions; and
- ◆ Custodial care.

### ***Skilled Nursing Facility Benefits***

*Please note: Your stay in a skilled nursing facility must be pre-certified under the Care Management Program described earlier in this SPD.*

A skilled nursing facility is a special facility that offers 24-hour nursing care outside of a traditional hospital setting.

A physician may recommend continuing care in a skilled nursing facility. The Student Health Program covers all medically necessary eligible charges. To be covered, a skilled nursing facility must be:

- ◆ Accredited as a skilled nursing facility by The Joint Commission on Accreditation of Health Care Organizations;
- ◆ Recognized and eligible for payment under Medicare as a skilled nursing facility; and
- ◆ Recognized by the Program as a skilled nursing facility;

If you are confined in a licensed skilled nursing facility, the Student Health Program will pay 100% of the Reasonable and Customary Charge for medical services for the first 30 days, then 80% of the Reasonable and Customary Charge after the deductible for additional days. The 30 days that are paid at 100% are in combination with all other covered inpatient days.

Covered services include:

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

A physician must prescribe care in a skilled nursing facility and the patient must be under a physician's supervision throughout the stay.

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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In order to be covered by the Program, a skilled nursing facility may not:

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

### ***Hospice Care Benefits***

*Please note: Hospice care must be pre-certified under the Care Management Program described earlier in this SPD.*

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

Hospice care is covered at 100% of the Reasonable and Customary Charge.

The patient is cared for by a team of professionals and volunteer workers, which generally includes a doctor and a registered nurse, and may include a dietary counselor, home health aide, medical social worker, and others.

The goals of the hospice are to provide an alert and pain-free existence for the patient and to keep the family actively involved in the care. Covered hospice care services include:

- ◆ Inpatient care;
- ◆ Nutritional counseling and special meals;
- ◆ Part-time nursing;
- ◆ Homemaker services;
- ◆ Physical and chemical therapy;
- ◆ Durable medical equipment;
- ◆ Doctor home visits; and
- ◆ Bereavement and counseling services for spouse, same sex domestic partner and children during the six-month period following the date of death, limited to a combined maximum of six visits.

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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

- ◆ Any curative or life prolonging procedures;
- ◆ Services of a family member or individual who normally resides in your home; and
- ◆ Any period when the individual receiving hospice care is not under a physician's care.

Certain benefits may be paid for outpatient (in-home) hospice care. For details, please call Student Health Program Customer Service. To be covered, the hospice program must be licensed and the attending physician must certify that the terminally ill covered person has a life expectancy of six months or less.

### ***Surgery***

Surgery for the treatment of disease or injury, and sterilization procedures are covered under the Student Health Program. Separate payment will not be made for inpatient pre-operative care or post-operative care normally provided by the surgeon as part of the surgical procedure, as these are included in the global surgical fee.

For related operations or procedures performed through the same incision or in the same operative field, the Program pays the surgical allowance for the highest paying procedure.

When two or more unrelated operations or procedures are performed at the same operative session, the Program pays the surgical allowance for the highest cost procedure, plus: 75% of the allowance for the second highest cost procedure; and 50% of the allowance for each subsequent procedure performed.

Benefits may also be provided for services of a physician who actively assists the operating surgeon when it is determined that the condition of the patient or the type of surgical service requires such assistance.

### ***Transplants***

*Please note: All transplants must be pre-approved and pre-certified under the Care Management Program described earlier in this SPD. Procurement of the organ and performance of the transplant must take place at a Johns Hopkins Employer Health Programs designated transplant center in the United States.*

The Student Health Program will pay benefits for non-experimental and non-investigational transplants of the human heart, kidney, lung, heart/lung, bone marrow, liver, pancreas, and cornea. No

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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benefits are paid for transplants that are experimental (as described later in this SPD under **What's Not Covered by the Student Health Program**). The Program will pay covered expenses for human-to-human organ or tissue transplants incurred by you or your dependent as a recipient during a transplant benefit period which begins five days before and ends 18 months after the date of the organ or tissue transplant. Coverage is contingent upon continuing to meet the criteria for Johns Hopkins Employer Health Programs transplant approval until the date of the transplant. Covered services include:

- ◆ Inpatient or outpatient hospital charges for treatment and surgery by a Johns Hopkins Employer Health Programs designated transplant center;
- ◆ Tissue typing;
- ◆ Removal of organ;
- ◆ Obtaining, storing, and transporting the organ; and
- ◆ Travel expenses for the recipient, if medically necessary, to and from the transplant center, up to \$10,000 for each transplant completed.

Please note that no benefits will be paid for the following:

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

### **Mental Health and Substance Abuse Services**

The Student Health Program provides benefits for inpatient and outpatient mental health and substance abuse care, including alcohol detoxification. Outpatient care includes psychotherapy and counseling for substance abuse. Benefits are only provided when the services are received from independently credentialed mental health/substance abuse providers that are psychiatrists, clinical psychologists, certified addiction counselors or licensed clinical social workers (ACSW, LCSW, MSW). Graduate Student Counselors are not covered providers and benefits are not provided for their services.

There is a total lifetime combined inpatient and outpatient maximum benefit of \$250,000 for substance abuse care. This maximum includes benefits for all care received.

## ***STUDENT HEALTH PROGRAM COVERED SERVICES AND SUPPLIES***

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*Outpatient mental health care:* Benefits for outpatient mental health care will be paid at 52% of the Reasonable and Customary Charge for the first 20 visits per calendar year, after the deductible. Additional visits will be paid at 50% of the Reasonable and Customary Charge.

*Inpatient mental health care:* Facility charges will be paid at 100% of the Reasonable and Customary Charge for the first 30 days during any calendar year. Thereafter, charges will be paid at 80% of the Reasonable and Customary Charge, after the deductible. You pay the remaining 20%, plus any charges above the Reasonable and Customary Charge. You must obtain pre-certification for the inpatient admission or a penalty or complete denial of coverage will apply. Physician services will be paid at 80% of the Reasonable and Customary Charge, after the deductible.

*Outpatient substance abuse care:* Facility charges for outpatient substance abuse care will be paid at 100% of the Reasonable and Customary Charge for up to 30 visits during a calendar year. Physician services will be paid at 80% of the Reasonable and Customary Charge, after the deductible.

*Inpatient substance abuse care:* Facility fees will be paid at 100% of the Reasonable and Customary Charge for seven days per calendar year for detoxification, then at 80% of the Reasonable and Customary Charge, after the deductible, for additional days. Substance abuse rehabilitation will be covered at 100% of the Reasonable and Customary Charge for up to 30 days per calendar year, then at 80% of the Reasonable and Customary Charge, after the deductible. You pay the remaining 20%, plus any charges above the Reasonable and Customary Charge. You must obtain pre-certification for the inpatient admission or a penalty or complete denial of coverage will apply. Physician services will be paid at 80% of the Reasonable and Customary Charge, after the deductible.

*Partial Hospitalizations:* Two partial hospitalization days will equal one inpatient hospital day and will be paid according to the inpatient benefit level.

**Please note: All inpatient and outpatient days and visits for substance abuse care are limited to a combined lifetime maximum of 120 days/visits.**

**Note:** You must receive pre-certification for all inpatient, inpatient residential and outpatient facility treatment programs for mental health and substance abuse care by calling the confidential Student Health Program number on the back of your I.D. card. Failure to obtain pre-certification will result in a penalty or complete denial of coverage.

# ***WHAT'S NOT COVERED BY THE STUDENT HEALTH PROGRAM***

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## **What's Not Covered By the Student Health Program**

The Student Health Program does not cover the following:

- ◆ Any charges related to:
  - an injury arising out of, or in the course of, any employment for wage or profit; or
  - a disease covered with respect to employment, by any Workers' Compensation law, occupational disease law, or similar legislation;
- ◆ Any condition or injury arising from or occurring while engaged in any illegal activity;
- ◆ Any injury sustained or disease resulting from war, act of war, act of terrorism, riot, rebellion, civil disobedience, or from military service in any country;
- ◆ Charges by a provider who is an immediate relative of the patient (spouse, domestic partner, child, grandchild, brother, sister, in-law, grandparent or parent) or who resides in the patient's home. Charges for services prescribed for oneself. This exclusion also applies to charges for prescription drugs prescribed by an immediate relative;
- ◆ Charges for equipment that does not meet the definition of Durable Medical Equipment earlier in this SPD, including air conditioners, humidifiers, dehumidifiers, purifiers or physical fitness equipment, whether or not recommended by a doctor;
- ◆ Charges in excess of the Reasonable and Customary Charge by similar providers for the same services or supplies in the same geographic area. Johns Hopkins Employer Health Programs determines what is a Reasonable and Customary Charge.
- ◆ Charges incurred when you are not covered under the Student Health Program;
- ◆ Charges excluded under the Coordination of Benefits provisions set forth later in this SPD;
- ◆ Charges that would not be made if no coverage by the Program existed;
- ◆ Charges for which you are not legally required to pay;
- ◆ Charges in excess of the Reasonable and Customary Charge or above the allowable lifetime or annual maximums;

## ***WHAT'S NOT COVERED BY THE STUDENT HEALTH PROGRAM***

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- ◆ Claims filed more than 18 months after the expenses were incurred;
- ◆ Contraceptive medications, devices or methods that are not prescribed by a physician, and insertion of Norplant;
- ◆ Controlled substances, hallucinogens, or narcotics not administered on the advice of a doctor;
- ◆ Convenience items, such as telephone and television rental, slippers, meals for family members, or first aid kits and supplies;
- ◆ Cosmetic surgery except:
  - when resulting from an accidental injury or illness (unless the Program would exclude coverage for the injury or illness for a reason other than it occurred before coverage began);
  - because of a congenital malformation of a child; or
  - because of a mastectomy (see **Women's Health And Cancer Rights Act Of 1998**, earlier in this SPD);
- ◆ Coverages refused by another plan as a penalty for non-compliance with that plan's requirements;
- ◆ Custodial care, residential care, or rest cures;
- ◆ Dental treatment except if rendered as initial treatment as a result of accidental injury to the jaws, sound natural teeth, mouth, or face, provided care commences within 72 hours of the accident. Services directly related to the care, filling, removal or replacement of teeth or the treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth are not covered;
- ◆ Drugs that are non-prescription, non-legend, or over-the-counter, or to replace lost or stolen drugs;
- ◆ Education, vocational, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-medically necessary education. Your school may provide these services to you through another program;
- ◆ Emergency room services or treatments in cases other than in emergency situations;
- ◆ Expenses in connection with an injury arising out of or relating to an accident involving the maintenance or use of a motor vehicle (other than a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle, motorized pedal cycle or like type vehicle). This exclusion shall apply to those expenses up to the minimum amount required by law in the state of residence

## ***WHAT'S NOT COVERED BY THE STUDENT HEALTH PROGRAM***

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for any injury arising out of an accident of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance. However, this exclusion does not apply to a covered person who is a non-driver when involved in an uninsured motor vehicle accident;

- ◆ Expenses related to third-party liability, unless otherwise payable as described under the heading **When the Student Health Program May Recover Payment**, later in this SPD;
- ◆ Expenses related to exercise programs or use of exercise equipment, special diets or diet supplements, Nutri System Program, Weight Watchers or similar programs and hospital confinements for weight reduction programs;
- ◆ Expenses related to artificial reproductive procedures, including but not limited to artificial insemination, in vitro fertilization and related techniques, gamete intra fallopian tube transfer (GIFT), ovum transfer and embryo transfer;
- ◆ Experimental treatment, defined as the use of any treatment, procedure, facility, equipment, drug or drug usage, device or supply which the Plan Administrator determines, in its sole and absolute discretion, is being studied for safety, efficiency, and effectiveness and/or which has not received or is awaiting endorsement for general use within the medical community, by government oversight agencies, or other appropriate medical specialty societies at the time services are rendered.

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

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- If the drug, device, equipment, treatment or procedure, or the patient informed consent document utilized with the drug, device, equipment, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if Federal law requires such review or approval;
- If Reliable Evidence shows that the drug, device, equipment, treatment or procedure is the subject of ongoing phase II clinical trials, is the subject of research, experimental study or the investigational arm of ongoing phase III clinical trials, or is otherwise under study to

## ***WHAT'S NOT COVERED BY THE STUDENT HEALTH PROGRAM***

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

- If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, equipment, treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

- ◆ Foot devices, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge; or they are custom-molded and related to a specific medical diagnosis. Orthopedic shoes (not integral to a brace), supportive devices for the feet and orthotics used for sport and leisure activities are not covered;
- ◆ Eyeglasses, contact lenses, eye refractions, or the examinations for their fitting or prescription, except when medically necessary after cataract surgery or for aphakic patients and soft lenses or sclera shells intended for use in the treatment of medical conditions or injury;
- ◆ Hearing aids, or the examination for their fitting or prescription;
- ◆ Hypnosis or biofeedback training;
- ◆ Infertility services for any reasons;
- ◆ Immunizations and inoculations for any reason, except for dependent children;
- ◆ Myopia or hyperopia correction by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy or laser surgery and all related services;
- ◆ Nicotine addiction treatment, or smoking cessation programs;
- ◆ Pre-existing conditions, except as described under the heading **Pre-Existing Conditions** earlier in this SPD;

## ***WHAT'S NOT COVERED BY THE STUDENT HEALTH PROGRAM***

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- ◆ Private room charges beyond the amount normally charged for a semi-private room, unless a private room is medically necessary;
- ◆ Registered inpatient services if admitted on a Friday, Saturday or Sunday unless required as a result of emergency sickness or accident care. Sunday admissions will only be covered if medically necessary for scheduled surgery on Monday morning;
- ◆ Replacement of braces or prosthetic devices, unless there is sufficient change in the patient's physical condition to make the original brace or device no longer functional;
- ◆ Reversals of sterilization procedures such as vasectomies and tubal ligations;
- ◆ Routine foot care (including any service or supply related to corns, calluses, flat feet, fallen arches, non-surgical care of toenails, and other symptomatic complaints of the feet where surgery is performed) and orthotics used for sport and leisure activities;
- ◆ Services and supplies not recommended and approved by a doctor;
- ◆ Services and supplies paid in full or in part under any other plan of benefits or for services and supplies for which you are not required to pay;
- ◆ Services and supplies not specifically listed as covered in this SPD;
- ◆ Services performed by a doctor or other professional provider enrolled in an education, research, or training program when such services are primarily provided for the purposes of the education, research, or training program;
- ◆ Sexual dysfunction treatment not related to organic disease;
- ◆ Speech therapy for developmental disabilities such as stuttering, articulation disorders, tongue thrust, lisping, etc.;
- ◆ Surgical treatment of obesity or morbid obesity, including when the surgery is for treatment of co-morbid conditions;
- ◆ Surrogate motherhood treatment, including any charges related to giving birth or for treatment of the newborn child resulting from the surrogate motherhood;
- ◆ Telephone consultation charges, missed appointment charges, or charges for the completion of forms;

## ***WHAT'S NOT COVERED BY THE STUDENT HEALTH PROGRAM***

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- ◆ Transsexualism, gender dysphoria, or sexual reassignment or change, including medication, implants, hormone therapy, surgery, medical, or psychiatric treatment;
- ◆ Travel, whether or not recommended by a physician, except as specifically provided in this SPD;
- ◆ Treatment which is not medically necessary or above the allowable lifetime or annual maximums;
- ◆ Treatment which is not performed by an appropriate licensed professional provider acting within the scope of the provider's license;
- ◆ Treatment for which a third party may be liable, unless otherwise payable as described under **When the Program May Recover Payment (Reimbursement and Subrogation)**, later in this SPD; and
- ◆ Wigs and artificial hair pieces or any drug—prescription or otherwise—used to treat baldness (except in cases of baldness resulting from chemotherapy, radiation therapy, or surgery, in which case benefits are limited to one wig once every 24 months up to a \$350 maximum benefit as coordinated through the Care Management Program).

*Please note: This is not a complete list. If you are not sure if an expense is covered after reviewing this list, please call Student Health Program Customer Service at (410) 424-4485 or (888) 400-0091.*

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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### **Other Information About Your Student Health Program Benefits**

#### **Filing A Claim**

You or your provider will need to file a claim in order to receive benefits. To submit your claim, complete a claim form, attach your itemized bills to it, and send it to the address shown on the form. Claims should be reported promptly, and no claims will be accepted after 18 months from the date services or supplies were provided. Send all claims to:

Johns Hopkins Employer Health Programs  
Student Health Program  
6704 Curtis Court  
Glen Burnie, Maryland 21060

Itemized bills must include the following information:

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

Claim forms are available at The Johns Hopkins University School of Medicine Registrar's Office, the Bloomberg School of Public Health Student Accounts Office, University Health Services (UHS) Benefits Office; or Johns Hopkins Employer Health Programs. To avoid delay in handling your claim, answer all questions completely and accurately. ***Expenses cannot be processed without your signature in the appropriate areas of the form.***

More information about your claims and appeals rights is set forth below under **Claims for Benefits** in the **Administrative Information** section.

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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### **What Happens When You Have Duplicate Coverage**

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

The Student Health Program, like most group health plans, includes a Coordination of Benefits (COB) provision. The purpose of this provision is to limit the total amount you may receive from all medical plans to no more than 100% of the covered charges.

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

If the Student Health Program is your Secondary Plan, only covered expenses up to the amount the Program would otherwise pay may be covered. Any applicable co-pays, coinsurance or deductibles under the two plans still apply.

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

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

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

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

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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If you have enrolled your spouse/same sex domestic partner in the Student Health Program and your spouse/same sex domestic partner loses coverage under his or her other plan, the Student Health Program becomes primary for both of you and any covered dependent children.

Please note that the Student Health Program is the Secondary Plan to any other plan covering a qualified beneficiary who has elected COBRA.

The Student Health Program is the Primary Plan if you are covered under the Program as an active employee and you are also covered by Medicare. Similarly, if you are covered under the Program as an active employee the Program is the Primary Plan for your covered spouse if your spouse is covered by Medicare. If you are not covered as an employee, the Student Health Program is Secondary to Medicare. In all cases, the Student Health Program is Secondary to Medicare if your same-sex domestic partner is covered by Medicare. If someone is eligible for Medicare but does not enroll for Medicare, the Program will pay Secondary benefits as though he or she had enrolled for Medicare.

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

### **When the Student Health Program May Recover Payment**

If you or your dependents have an injury, illness or other condition that is covered by the Student Health Program and for which a third party might be liable, you must notify Johns Hopkins Employer Health Programs as soon as possible. You must comply with the Student Health Program's Reimbursement and Subrogation rights set forth below.

#### **Reimbursement**

The Student Health Program's reimbursement provisions apply when you or your dependents receive, or in the future may receive, any amounts by settlement, verdict or otherwise, including from an insurance carrier, for an injury, illness or other condition. We call these amounts a "Recovery". For purposes of these reimbursement rules and the subrogation rules below, your dependents include your same-sex domestic partner. If you or your dependents have received a Recovery, the Program will subtract the amount of the Recovery from the benefits it would otherwise pay for treatment of the

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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injury, illness or other condition. If there is a possible future Recovery, the Program may delay paying benefits until the Recovery is received, and then subtract the amount of the Recovery.

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

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

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

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

### **Subrogation**

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

The Program is subrogated to all of your and your dependents’ rights against any party (including an insurance carrier) that is or may be liable for your and your dependents’ injury, illness or other condition or for paying for treatment of the injury, illness or other condition. The Program is

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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subrogated to the extent of the amount of the benefits it pays to or on behalf of you or your dependents. The Program may assert its subrogation right independently of you and your dependents.

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

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

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

### **When Medical Coverage Ends**

Your coverage under the Student Health Program described in this SPD will end on the earliest of the following dates:

- ◆ The end of the month in which you are no longer registered as a student at the JHU School of Medicine, Bloomberg School of Public Health, or JHH Schools of Medical Imaging (but see COBRA Continuation Coverage described next);
- ◆ The date when you report for active duty as a member of the armed forces of any country;
- ◆ The date the Student Health Program is terminated or the date your school terminates its participation in the Program;
- ◆ The end of the month in which you elect to no longer be covered under the Student Health Program or the date you stop making required contributions for coverage under the Program.

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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Coverage for a dependent will end on the earliest of:

- ◆ The end of the month in which your coverage ends;
- ◆ The end of the month in which he/she no longer qualifies as an eligible dependent as explained earlier in this SPD (but see COBRA Continuation Coverage described next);
- ◆ The end of the month in which a dependent child reaches age 19;
- ◆ The end of the month in which you elect to no longer cover your dependents under the Student Health Program or the date you stop making required contributions for dependent coverage under the Program;
- ◆ The date your dependent enters military service.

For certain of the above events, you or your dependents may be able to continue coverage by self-payment under COBRA, as explained next.

### **COBRA Continuation Coverage**

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

If you elect COBRA coverage, it will not apply to your same-sex domestic partner. Domestic partners may not elect COBRA coverage themselves.

Coverage under the Student Health Program may be continued under COBRA for up to 18 months for you, your spouse, and your eligible dependents, if coverage is lost due to your no longer being registered as a student with any of the schools that sponsor the Program. Coverage may be continued for up to 24 months if you are also employed by one of the schools and your employment ends because you are called up for military duty that is covered by the Uniformed Services Employment and Reemployment Rights Act (commonly known as “USERRA”).

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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

If you, your spouse, or any of your dependents is Social Security disabled at any time during the first 60 days of COBRA coverage, coverage for the disabled individual, and each of the individual's family members, may be extended for an additional 11 months, for a total of 29 months. Premiums for the additional 11 months will increase from 102% to 150% of the full cost. The Plan Administrator must be notified in writing of Social Security Disability within 60 days after the date of determination and before the 18 months of regular COBRA coverage ends, or the 11 additional months of COBRA coverage will not be provided. If Social Security notifies you or any of your dependents that he or she is no longer disabled, then the additional 11 months of COBRA coverage no longer applies and you must notify the Plan Administrator within 30 days of the Social Security notice. Please contact the Plan Administrator if you have any questions about your eligibility.

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

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

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

Your dependent children may individually elect COBRA continuation coverage for up to 36 months if they stop being eligible for dependent coverage as explained earlier in this SPD.

If one of the above events that allow COBRA coverage to be continued for 36 months occurs after an event that allows COBRA coverage to be continued for 18 months and before the 18 months has expired, then COBRA coverage may be elected for up to 36 months, measured from the first event.

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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If another event occurs, you, your spouse or dependent child must notify the Plan Administrator in writing within 60 days after the second event. If the Plan Administrator is not notified in time, COBRA may not be continued past 18 months.

You, your spouse, or your dependents will be informed of the right to continue coverage under COBRA in the event:

- ◆ You are no longer registered as a student with any school that sponsors the Program;
- ◆ You die.

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

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

### **Electing COBRA Coverage**

You, your spouse or dependent children will have 60 days from the date coverage would otherwise end or from the time notice of COBRA rights is given (whichever is later) to elect to continue your Student Health Program medical coverage under COBRA. If COBRA coverage is not elected on time, coverage under the Student Health Program will end.

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

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

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

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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If the Student Health Program benefits change, or if the coverage costs change, the COBRA continuation coverage benefits and their costs will change as well. Covered persons will be notified of any changes.

### **When COBRA Coverage Ends**

The right to COBRA continuation coverage will end before the conclusion of the 18, 29 or 36 month period, whichever applies, if:

- ◆ A covered individual becomes covered under another group medical plan after COBRA coverage is elected (unless a pre-existing condition limitation would prevent the individual from receiving benefits from the new plan for a particular illness or injury);
- ◆ A covered individual becomes covered by Medicare after COBRA coverage is elected (*Please note: your spouse and dependent children are entitled to COBRA continuation coverage for 36 months if **you** become covered by Medicare after COBRA coverage for them is elected — this 36-month period begins with the date your COBRA coverage began*);
- ◆ The premium is not received on a timely basis; or
- ◆ The Student Health Program stops providing group medical coverage for all active students.

### **When You Become Covered By Medicare**

If you are still an active participant when you become covered by Medicare, your Student Health Program coverage will coordinate with your Medicare coverage. Be sure to advise your health care provider that you have both coverages. Make clear to your provider that your coverage under the Student Health Plan is because you are a student.

### **Benefits You Will Receive From Medicare**

When you reach age 65, you will be eligible for Medicare hospital (Part A) and medical (Part B) benefits. You will not be covered by Medicare until you enroll. You may become eligible for Medicare benefits at an earlier date if you become permanently disabled or have end stage renal disease. The exact amount of the benefits you receive is determined by the government, and may be adjusted in future years to reflect changes in medical costs.

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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### **Basic Administrative Information About Your Benefits**

This section of your SPD contains information regarding the administration and funding of the Student Health Program.

#### **Name of Program/Plan**

The Johns Hopkins University School of Medicine and Bloomberg School of Public Health Student Health Program.

#### **Group Number**

0016

#### **Name and Address of Plan Administrator**

The Johns Hopkins University School of Medicine and Bloomberg School of Public Health  
733 N. Broadway  
Broadway Research Building, Suite 147  
Baltimore, MD 21205

#### **Administrator Identification Number**

52-0595110

#### **Plan Number**

513

#### **Type of Administration**

Contract administration by Johns Hopkins Employer Health Programs, Inc.

#### **Plan Sponsor**

The Johns Hopkins University School of Medicine and the Bloomberg School of Public Health  
733 N. Broadway  
Room 147 Broadway Research Building  
Baltimore, MD 21205

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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### **Plan Supervisor**

Johns Hopkins Employer Health Programs  
6704 Curtis Court  
Glen Burnie, MD 21060  
410-484-4485  
888-400-0091

### **Agent for Legal Process**

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

### **Plan Year**

July 1 -- June 30.

### **Source of Program Benefit Payments**

Benefits under the Program are paid from the general assets of The Johns Hopkins University School of Medicine, Bloomberg School of Public Health and The Johns Hopkins Hospital. Benefits are not paid or administered by an insurance company.

### **Claims for Benefits**

In order for you to receive medical benefits under the Program, you or your provider must file a claim. Following are the Program's procedures for filing claims and appealing claim denials.

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

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

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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

Certain services and supplies must be “pre-certified” through the Care Management Program in order to be covered or to avoid a penalty. See the earlier discussion in this SPD about the **Care Management Program** and the **Medical Benefits At-A-Glance** chart. If a service or supply must be pre-certified, a request for pre-certification is a “**Pre-Service Claim**”.

If a service or supply must be pre-certified and it is requested for Urgent Care, it is an “**Urgent Care Claim**”. A service or supply is considered to be requested for Urgent Care if either of these statements would be true:

- ◆ The life or health of the patient or the ability of the patient to regain maximum function could be seriously jeopardized if the pre-certification decision is not made within 72 hours. Whether the “serious jeopardy” test is met is determined by Employer Health Programs based on the standards of a prudent layperson with average knowledge of health and medicine. However, if a physician with knowledge of the patient’s medical condition determines that the serious jeopardy test is met, the physician’s determination will be followed.
- ◆ A physician with knowledge of the patient’s medical condition determines that the patient would be subject to severe pain that cannot be adequately managed without the requested service or supply.

If a service or supply does not need to be pre-certified, a claim for payment is a “**Post-Service Claim**”.

### ***Filing a Claim***

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

To file a Post-Service Claim, you or your provider must complete and submit a claim form and attach itemized bills with the information described below. Claims should be reported promptly, and no claims will be accepted more than 18 months after the treatment was provided. Unless a different address is shown on the top of the form, send all Post-Service Claims to:

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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Student Health Program  
c/o Johns Hopkins Employer Health Programs  
6704 Curtis Court  
Glen Burnie, Maryland 21060

Itemized bills must include the following information:

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

Claim forms are available at The Johns Hopkins University School of Medicine Registrar's Office, the Bloomberg School of Public Health Student Accounts Office, the University Health Services (UHS) Benefits Office and from Johns Hopkins Employer Health Programs. To avoid delay in handling your claim, answer all questions completely and accurately. *Claims cannot be processed without your signature where required on the form.*

### ***Reducing or Terminating an Approved Course of Treatment***

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

### ***Extending an Approved Course of Treatment***

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

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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### ***Authorized Representative***

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

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

### ***Claims and Appeals Procedures***

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

#### **Urgent Care Claims**

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

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

#### **Pre-Service Claims**

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

Unless additional information is needed, you will be notified of a Pre-Service Claim decision within 15 days after the claim is properly filed. If there are matters beyond Employer Health Programs' control,

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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this period may be extended up to 15 more days. If an extension is needed, you will be told before the initial 15 day period ends why an extension is needed and when a decision is expected.

### **Post-Service Claims**

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

### ***If Additional Information is Needed***

#### **Pre-Service and Post-Service Claims**

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

#### **Urgent Care Claims**

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

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

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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### ***If Your Claim is Denied***

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

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

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

### ***First Level Appeal***

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

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

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

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

Student Health Program  
c/o Johns Hopkins Employer Health Programs  
6704 Curtis Court  
Glen Burnie, MD 21060

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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

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

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

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

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

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

### ***When Your First Level Appeal Will Be Decided***

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

- ◆ **Urgent Care Claim** -- You will be notified of the decision within 36 hours after your appeal is filed.
- ◆ **Pre-Service Claim** -- You will be notified of the decision within 15 days after your appeal is filed.

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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- ◆ **Post-Service Claim** -- You will be notified of the decision within 30 days after your appeal is filed.
- ◆ **Reduction or termination of an approved course of treatment** -- You will be notified of the decision within 30 days after your appeal is filed. However, if you filed your appeal within 10 days after being notified of the proposed action, the course of treatment will not be reduced or terminated before your appeal is decided. (See below for additional Final Appeal rights you may have before treatment is reduced or terminated.)
- ◆ **Request to extend an approved course of treatment** -- If your appeal is filed before the additional treatment has been provided, the Pre-Service Claim time applies. If your appeal is filed after the additional treatment has been provided, the Post-Service Claim time applies.

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

### ***Final Appeal***

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

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

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

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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

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

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

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

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

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

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

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

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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**Urgent Care claim** -- You will be notified of the decision within 36 hours after your Final Appeal is filed.

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

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

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

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

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

### **Protected Health Information**

The Program may create or obtain information which relates to a Program participant's physical or mental health condition, treatment or payment for health care. When this information is individually identifiable, it is called "Protected Health Information" (PHI) under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (collectively "HIPAA").

### **Permitted Use and Disclosure**

The Program (which includes the Program's agents for purposes of this Section) may disclose PHI to the Plan Sponsor (which includes the Plan Sponsor's agents for purposes of this Section), and the Plan Sponsor may use or disclose PHI obtained from the Program, only for the following purposes:

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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- ◆ To assist Program participants with resolution of claims;
- ◆ To decide appeals of benefit determinations;
- ◆ To select and monitor Program service providers;
- ◆ To obtain premium bids from health plans to provide coverage under the Program;
- ◆ To evaluate Program design and modify, amend or terminate the Program;
- ◆ To disclose information on whether the individual is participating in the Program, or is enrolled in or has disenrolled;
- ◆ To consult with the Program's service providers regarding administrative functions, including payment, health care operations and activities performed by the Program which support treatment;
- ◆ To seek bids and negotiate for stop-loss insurance coverage (if applicable); and
- ◆ As otherwise required by law.

The Program may disclose PHI to the Plan Sponsor for purposes not stated above only after authorization is obtained from the Program participant.

### **Plan Sponsor's Certification**

Except as otherwise permitted or required by law, as a condition to obtaining PHI from the Program, its business associates, insurers and HMOs, the Plan Sponsor agrees to:

- ◆ Not use or further disclose PHI other than as permitted above, or as otherwise permitted by HIPAA or as required by law;
- ◆ Ensure that any agents or subcontractors who receive PHI from the Plan Sponsor that was obtained from the Program will agree to the same restrictions and conditions that apply to the Plan Sponsor;
- ◆ Not use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of Plan Sponsor;
- ◆ Report to the Program any known use or disclosure of PHI that is inconsistent with the uses or disclosures allowed above;
- ◆ Make PHI available to the Program for response to a participant's request for access to the participant's PHI in a designated record set, as provided by HIPAA;
- ◆ Make PHI available to the Program for amendment, and incorporate any amendments to PHI, as provided by HIPAA;
- ◆ Make available to the Program the information required to provide an accounting of disclosures as provided by HIPAA;

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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- ◆ Make its internal practices, books, and records relating to use and disclosure of PHI received from the Program available to the Secretary of the Department of Health and Human Services, for purposes of determining the Program's compliance with HIPAA;
- ◆ If feasible, return or destroy all PHI received from the Program when the Plan Sponsor no longer needs the PHI for the purpose for which it was disclosed to the Plan Sponsor, except if return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible; and
- ◆ Ensure adequate separation between the Program and the Plan Sponsor, as stated below.

The applicable HIPAA Regulations are set forth at 45 CFR Part 164, including any amendments made to these requirements.

### **Separation Between Program and Plan Sponsor**

Only the following persons under the control of the Plan Sponsor ("Plan Sponsor Representatives") may be given access to PHI from the Program:

- ◆ Persons who, in the ordinary course of business, receive PHI relating to treatment, payment or health care operations under the Program, including any persons who hear appeals of claim denials under the Program;
- ◆ Plan Sponsor's Associate Dean/Registrar, the Student Benefits Manager and the Student Accounts Coordinator, and those employees of the Plan Sponsor who report to the Associate Dean/Registrar, the Student Benefits Manager and the Student Accounts Coordinator in the ordinary course of performing job duties for the Plan Sponsor that relate to Program administration functions;
- ◆ Plan Sponsor's Legal Counsel; and
- ◆ Individuals or titles appointed in writing by the Plan Administrator to perform specific tasks for the Program, provided the Plan Administrator documents such appointment in writing and maintains such appointment available for inspection to the same extent as this Program is available for inspection.

These Plan Sponsor Representatives may have access to and may use PHI from the Program only for Program administration functions performed by the Plan Sponsor. Program personnel will assure that the minimum necessary PHI is made accessible to the Plan Sponsor Representatives for these purposes. These Plan Sponsor Representatives will be trained in the limits on access to, and the proper use of, PHI from the Program. In addition, these Plan Sponsor Representatives will be subject to appropriate sanctions, as provided by the Plan Sponsor's policies, for improper access to, or use or

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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disclosure of, PHI from the Program, and for any failure to comply with any provision of the Plan Sponsor's certification.

### **Security of Electronic PHI**

Electronic PHI means Protected Health Information which is (1) transmitted by electronic media, or (2) maintained in electronic media.

Except when the only Electronic PHI disclosed to Plan Sponsor is “summary health information” (as defined in HIPAA) or enrollment/disenrollment information, or is validly authorized by the Program participant, the Plan Sponsor agrees to:

- ◆ Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Program;
- ◆ Ensure that the separation between the Program and the Plan Sponsor as required above is supported by reasonable and appropriate security measures;
- ◆ Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- ◆ Report to the Program any security incident of which it becomes aware. (For purposes of this provision, “security incident” means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.)

### **Your Rights Under ERISA**

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

- ◆ You can examine, free of charge, all of the official documents related to the Program (such as plan documents, insurance contracts, annual reports, SPDs, any other plan agreements, or any other documents filed with the U.S. Department of Labor). You can examine copies of these documents in the Plan Administrator’s office.
- ◆ If you wish, you can get your own copies of the plan documents by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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### **Additional ERISA Rights**

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

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

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

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

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

If you have any questions about this Program, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, as listed in the telephone directory, or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., NW, Washington, D.C., 20210.

## ***OTHER INFORMATION ABOUT YOUR STUDENT HEALTH PROGRAM BENEFITS***

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### **Student Health Program's Rights**

The benefit plan described in this SPD is for student participants only. The Johns Hopkins University School of Medicine, the Bloomberg School of Public Health and the Johns Hopkins Hospital School of Medical Imaging expect to continue this Program indefinitely, but reserve the right to modify, amend, suspend, or terminate the Program at any time, and for any reason without prior notification. You will be notified of any changes to this Program and how they affect your benefits, if at all. We have attempted to make the explanations of the Program as accurate as possible. However, should there be a discrepancy between this SPD and the provisions of the contracts or other plan documents, the provisions of the contracts or other plan documents will govern. You should not rely on any oral descriptions of the Program, since the written description in this SPD will always govern. To the extent any benefits under the Program are provided by an insurance policy, no benefits are provided by the Program except for those benefits, if any, which are paid by the insurance company which issues the policy.

### **Plan Administrator's Authority**

The Plan Administrator has discretionary authority to interpret the terms of the Student Health Program and to decide any questions of fact which relate to entitlement to benefits under the Program.

### **For More Information**

Please see your Student Health Program enrollment materials for additional information about the Program. If you have questions, you can speak with a Student Health Program Customer Service Representative by calling (888) 400-0091 or (410) 424-4485. Or, contact the Registrar's Office, School of Medicine, Student Accounts Office, Bloomberg School of Public Health, or JHH Schools of Medical Imaging.

PLEASE NOTE: This Summary Plan Description has been changed from the version of the Summary Plan Description that was distributed in 2005 so as to reflect certain benefit changes that take effect July 1, 2006. If you have any questions, please contact the Registrar's Office at the School of Medicine, the Student Accounts Office at the Bloomberg School of Public Health or a Student Health Program Customer Service Representative.