EHP MEMBER HANDBOOK

All Children's Hospital

JOHNS HOPKINS
HEALTH PLANS

Welcome to EHP.

Welcome to a healthier you.

Thank you for choosing Johns Hopkins Employer Health Programs (EHP) as your health plan. EHP has worked with your employer to craft a benefits package that covers essential preventive care as well as other important benefits to meet your health care needs. As your partner in well-being, we also offer many health and wellness services to give you additional support.

At EHP, we want you to take an active role in your health care. Getting started is easy — here are a few steps you can take right away to get the most from your health plan and take charge of your health.

1. **Select a primary care provider (PCP)** and schedule a well-visit appointment. Follow your PCP's advice for additional care and screenings.
2. **Sign up to access your member portal.** View your personal health record, submit reimbursement requests, track claims, request an ID card and more.
3. **Review your member handbook.** This document explains key health care terms, outlines how to access care and details other important benefit information.

We'll keep you informed of key benefits, plan updates and healthy habits. Visit our website, ehp.org, to find your Notice of Privacy Practices and to get the most accurate information about your medical and pharmacy benefits. Our website also features news, tools for healthy living, free health classes and a range of extras and EHP-only services, including:

- Complete coverage details in the **Benefits Explorer**
- **Telehealth** options for care from anywhere, including urgent care and mental health
- **Plan Perks** for free and discounted products and services
- Our **Provider Search Tool** — the easiest way to find the right care near you
  - » Cigna Nationwide Network — Find in-network providers for every EHP plan.
  - » Florida preferred Providers/Select pediatric providers — Find providers who are part of the preferred and select pediatric benefit tier.
- **Care Management** services for when you need extra help managing your health

Get timely updates from our monthly newsletter sent right to your email inbox. Scroll to the bottom of our web pages to find the sign-up option. You'll also receive our myEHP member newsletter three times per year, filled with helpful tips for living a healthy life.

We are excited to be a part of this next chapter in your health journey. Lasting change starts with small, consistent steps — and together, we'll turn those steps into meaningful progress toward a healthier you.

Sincerely,
Employer Health Programs

How to Use Your Handbook

Your Member Handbook is your guide to understanding how to use your health plan and get the most from your coverage. Please review this handbook and keep it in a safe, convenient location for future reference.

Here are a few things you can learn from this handbook:

- Who to call and where to go when you need care
- How EHP covers your prescriptions and where to get your prescriptions filled
- How to take advantage of your care team's health and wellness services

While this handbook is a guide to your coverage, you can find specific information about your plan and benefits on our website at **ehp.org**. Use our website to search for providers, explore your covered benefits, find important forms, and more.

Your legal entitlement to benefits under your EHP Medical Plan is determined only by your Summary Plan Description and not by this Handbook. For detailed information about your benefits, you should refer to your Summary Plan Description, which you can get from your HR Support Center by calling 443-997-5400.

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Get Started With EHP

Take these three steps to get off to a great start with EHP.

1. **Sign up for your member portal**

   HealthLINK@Hopkins is a secure member portal where you can keep track of your health care. View your personal health record, track your claims, request a new ID card, and more. You can also self-serve many Customer Service questions through your member portal.

   Visit **ehp.org** and click "Member Login" in the top right corner. Under "First Time Logging In?" click "Member Register." Fill in your member ID number, name, birth date and gender, then click "Next."

2. **Schedule a well-visit**

   We encourage all members to schedule a well-visit (checkup) with their PCP within 90 days of becoming a new member. This will allow your provider to learn about your health and guide you for further care.

   A PCP is an important part of your health care. If you don't already have a PCP or need to confirm that your PCP is in our network, go to **ehp.org** and use the Find a Provider tool. Search the Cigna PPO network for providers in Florida.

3. **Check out our health and wellness services**

   Adopting and maintaining healthy lifestyle habits is as important to your overall health as your treatment with your providers. EHP has helpful services to support you in achieving your best health.

   Attend one of our workshops to learn about managing a condition or to improve your nutrition and fitness. Or, partner with a care manager to coordinate your health care and prevent more serious conditions.

Learn more: **ehp.org/plan-benefits/health-programs-and-resources**

Learn About Your Coverage

Important Plan Documents

Schedule of Benefits (SOB): contains detailed information about your EHP coverage, deductibles, co-insurance and copays. You can view your SOB on our website at **ehp.org**.

Summary Plan Description (SPD): describes members' rights, benefits, and responsibilities under the plan in understandable language. To view or obtain a copy of your SPD, please call your HR Support Center at 443-997-5400.

Explanation of Benefits (EOB): tells members exactly which services their provider(s) has billed, what has been paid and at what rate, what has been denied and why, and what payment, if any, is the member's responsibility.

Note: Member reimbursements are sent separately along with an EOB that varies slightly from the standard EOB.

	❶	❷	❸	❹	❺	❻	❼	❽	❾	❿
						Patient Responsibility				
Date of Service/ Service Description	Total Charges	Plan Contractual Discounts	Allowed Amount	Not Covered	Paid Amount	Deductible	Copay	Co-insurance	Ineligible Charges	Remarks
03/16/2025	43.20	15.90	27.30	0.00	0.00	27.30	0.00	0.00	0.00	
MEDICAL SUPPLIES/EQUIPMENT										
03/16/2025	32.50	13.14	19.36	0.00	0.00	19.36	0.00	0.00	0.00	
MEDICAL SUPPLIES/EQUIPMENT										
03/16/2025	126.58	58.89	67.69	0.00	0.00	67.69	0.00	0.00	0.00	
MEDICAL SUPPLIES/EQUIPMENT										
03/16/2025	167.44	0.00	0.00	167.44	0.00	0.00	0.00	0.00	0.00	z45
MEDICAL SUPPLIES/EQUIPMENT										
03/16/2025	226.37	39.24	187.13	0.00	91.33	85.65	0.00	10.15	0.00	
MEDICAL SUPPLIES/EQUIPMENT										
TOTALS:	596.09	127.17	301.48	167.44	91.33	200.00	0.00	10.15	0.00	
						Provider May Bill You: $210.15				← ⓫

BENEFIT BALANCES: PLAN YEAR TO DATE

Amounts displayed are accurate as of the print date and are subject to change. Out-of-Pocket Accumulator totals include all copay, co-insurance and deductible amounts.

		2025
	In-Network Deductible Met of $200 Max	$200.00
	In-Network Copay/Co-insurance Amount	$10.15
	In-Network Out-of-Pocket Met of $2000 Max	$210.15
	Out-of-Network Deductible Met of $750 Max	$200.00
	Out-of-Network Copay/Co-insurance Amount	$10.15
	Out-of-Network Out-of-Pocket Met of $3500 Max	$210.15

* No one person will be required to satisfy more than the individual per-person deductible and out-of-pocket max.
* Expenses incurred by two or more persons can meet the family deductible and out-of-pocket max.

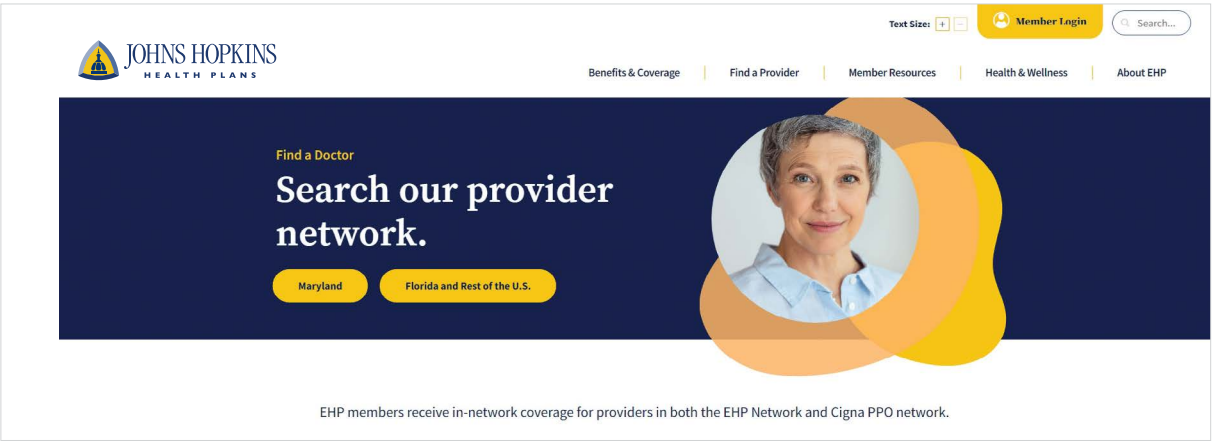
		2025
Family	In-Network Deductible Met of $400 Max	$265.46
	In-Network Copay/Co-insurance Amount	$65.15
	In-Network Out-of-Pocket Met of $4000 Max	$330.61
	Out-of-Network Deductible Met of $1500 Max	$265.46
	Out-of-Network Copay/Co-insurance Amount	$65.15
	Out-of-Network Out-of-Pocket Met of $7000 Max	$330.61

1. **Billed Amount:** This is the amount the doctor or facility charged for the service(s) that you received.
2. **Plan Contractual Discounts:** The savings on billed charges your plan has secured through contracts with your provider.
3. **Allowed Amount:** This is the maximum amount EHP will allow for the service(s) you received. Any copay and/or co-insurance amounts that you are responsible for paying are deducted from the allowed amount.
4. **Not Covered:** The amount that will not be considered for payment.
5. **Paid Amount:** The amount that EHP has paid to the provider for the service(s) that you received.
6. **Deductible:** The amount that you must pay within the plan year before EHP begins to pay benefits. Your Schedule of Benefits (SOB) or Summary Plan Description (SPD) will advise if you have a deductible and the amount of the deductible.
7. **Copay:** A copay is a fixed fee you must pay at the time of service.
8. **Co-insurance:** Co-insurance is a percentage of medical costs that you share with EHP.
9. **Ineligible Charges:** Certain services may not be covered by your plan. In that case, you will be responsible for the full amount.
10. **Remarks:** Additional information about aspects of the EOB.
11. **Provider May Bill Amount:** The amount that you are responsible for paying to the provider of service, when the provider of service is a network provider.

Find It Online

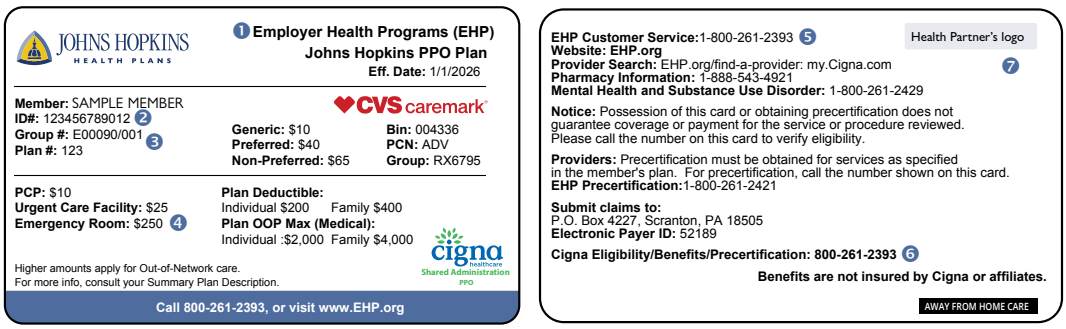
The EHP website **(ehp.org)** features a great deal of helpful information and resources. Use our website to:

- Search for health care providers by name, location, language spoken, gender, professional qualifications, and more
- Explore your benefits and view your SOB
- Access and download forms
- Learn about available health and wellness services
- Register for and log into your secure member portal, HealthLINK@Hopkins, where you can:
  - » Input and track your medical history
  - » Submit reimbursement requests
  - » Check the status of claims, access pharmacy information
  - » Review Utilization Management requirements, request a new ID card, and more
  - » Email Customer Service



Your Member ID Card

Your ID card identifies you as an EHP member and contains important information about you, your PCP, your copayments, and important phone numbers. Always carry your member ID card with you and present it when you receive health care services. If you haven't received one yet, please call Customer Service at 800-261-2393.



Above is a **sample** member ID card. Please review your actual card for your ID number and information specific to your coverage including:

1. Employer Member
2. ID number
3. Group number
4. Copayments
5. EHP member services contact information
6. National network contact information
7. Members residing in certain zip codes may have an additional logo in the top right corner on the back of the ID card. These members have access to additional in-network providers unique to their area through Cigna's PPO network.

Key Benefit Terms

Premium: The amount you pay for health insurance by payroll deduction.

Copay: A fixed fee that you are responsible for when receiving health care services or prescriptions. The amount depends on your specific coverage, the service, type of provider visit or prescription tier.

Co-insurance: A percentage of the cost for medical services that you pay when you receive health care services or prescriptions.

Claim: A bill for health care services that your health care provider sends to EHP for payment. If you seek care out-of-network, you may have to submit a claim for reimbursement after you pay your doctor's fees.

Deductible: The amount that you must pay within the plan year before EHP begins to pay benefits. Your Schedule of Benefits (SOB) or Summary Plan Description (SPD) will advise if you have a deductible and the amount of the deductible.

Prior Authorization: This means that a requested service must be medically reviewed and approved by EHP before the service is rendered.

Inpatient: A medical or behavioral health service that requires you to stay in the hospital—for at least one night—while under treatment.

Outpatient: A medical or behavioral health service that does not require a hospital stay for treatment. Generally, patients may leave the facility after the treatment or procedure.

Exclusive Provider Organization (EPO)

EHP's EPO plan offers coverage for in-network benefits only. Members may only use providers and facilities in the EHP Network (including the Cigna PPO network) and the EHP Preferred Network. Members may be responsible for all costs for out-of-network care. Please see the Emergencies section on page 15 for more information.

Preferred Provider Organization (PPO)

EHP's PPO plan offers coverage for in-network and out-of-network providers and facilities. Members may seek care outside of the EHP Network, EHP Preferred Network and Cigna PPO Network, but will pay more for those services.

Emergency care is covered at in-network and out-of-network hospitals. Please see the Emergencies section on page 15 for more information.

Where to Find Information About Your Specific Plan

The EHP website **(ehp.org)** is your source for convenient, up-to-date information about your EHP benefits and coverage specific to your employer. To view your benefits and coverage, simply go to **ehp.org** and select "Overview" under the Benefits and Coverage menu. Explore your plan by selecting your Employer from the drop-down field, along with your Plan Year and Plan Name, then click "Go" to view your Plan Overview.

Your Plan Overview will display your individual coverage and benefits, including medical, dental, vision and virtual visits. Select each one to view your specific coverage in each category. You can even search your schedule of benefits by keyword and category.

Your Summary Plan Description (SPD) is a detailed document that provides complete information about your EHP coverage and other employee benefits. You can get a copy of your SPD through your your HR Support Center by calling 443-997-5400.

For further questions regarding your benefits, or if you are still uncertain about your plan benefits and coverage, call EHP Customer Service at 410-424-4450 or 800-261-2393.

Non-Covered Benefits and Services

EHP does not cover services related to workers' compensation; automobile accidents; services deemed experimental, investigational or not medically necessary by EHP; or services listed as "non-covered benefits" in your SPD. Review your employer's SPD and SOB for details as to what is covered or not covered by your unique plan. If you have specific questions regarding your coverage, call Customer Service or log on to your secure account on HealthLINK@Hopkins. You can obtain a copy of your SPD through your your HR Support Center by calling 443-997-5400..

Continuation of Coverage

If a "qualifying event" would cause you and/or a family member to lose medical plan coverage, you and your covered family members may be eligible for continuation of coverage through COBRA.

To learn more about this continuation of coverage, including whether and how COBRA is offered, contact your HR Support Center at 443-997-5400 for plan-specific details.

New to Health Insurance? Here's How It Works With EHP.

Jan 1

Your coverage begins with your first monthly premium payment.

ID Card

Receive your member ID card
You will need this for all health care services, including picking up prescriptions at the pharmacy.

HealthLink

Sign up for HealthLINK@ Hopkins, your member portal
This is a great resource for you to view your personal health record, track your claims, change your primary care provider (PCP), request a new ID card, and more.

Preventative Care

Schedule your preventive care
You get these services at no charge when you see an in-network provider:

- Preventive exams and diagnostic services
- Routine preventive screenings
- Routine hearing exams

Urgent Care

Get any additional care you need
Locate your nearest in-network urgent care center and emergency room. Use urgent care when you are not able to see your PCP and use the ER for sudden and severe injuries and illnesses. If you need specialty care, review your SOB for coverage details. Select a provider from the EHP networks for your lowest costshares on covered benefits.

Deductible

Reach your deductible
To find out what your deductible is, look at your SOB: "Deductibles and Maximums."

Copay/ Co-insurance

Pay your share
After you meet your deductible, you'll pay a copay or co-insurance for covered services. EHP will pay the rest.

Out-of-Pocket

Reach your annual in-network out-of-pocket maximum
If you reach this limit, EHP will pay 100% of your in-network covered medical expenses for the rest of the plan year.

Dec 31

End of plan year

Find a Doctor

Search Our Provider Network

EHP offers members an extensive provider network, not just in Maryland, but nationwide, with many quality options in Florida. To find a doctor or health care facility visit **ehp.org/find-a-provider**. Select our networks based on you location, as described below.

Access Care in Florida and Nationwide

Nationwide Cigna PPO Network: You have access to a national network of more than one million providers and hospitals nationwide through the Cigna PPO network. EHP covers all health care services received from providers in the Cigna PPO network at the in-network benefit level. The Cigna PPO network is for medical services only. Routine dental and vision services are not covered within this network. Telemedicine services with Cigna PPO providers are covered. To search for a provider in the Cigna PPO network, call the toll-free phone number on the back of your EHP member ID card or visit **ehp.org/find-a-provider**, then click "Nationwide Cigna PPO Network." Note: some providers may not appear when searching as a guest. For the most complete search results, create a Cigna account and log in using your EHP membership information.

Florida Preferred Providers and Select Pediatric Providers: To find our subset of providers in Florida that align with EHP benefits and coverage options:

- Visit **ehp.org/find-a-provider**.
- Click **Florida Preferred Providers/Select Pediatric Providers.**
- Choose **Florida** under **Location**. Select **Specialist/Vendor for Service Type**. Click **Search**.
- Under **Network Option,** select **EHP Preferred Provider** or **EHP Select Pediatric Provider.** Click **Search** again.

Customer Service can also help you find a provider. Call the toll-free phone number on the back of your EHP member ID card.

Access Care in Maryland

- Search the EHP network for more than 14,000 health care providers and more than 30 hospitals
  in Maryland.
- Search the Cigna PPO nationwide network of more than one million providers and hospitals, including Maryland.

When searching the EHP Network, you can search for a provider by name, location and service type (including primary care, specialist, hospital, radiology or lab, behavioral health, and more). You can also filter those results by specialty, preferred provider network, language spoken and gender. The search tool also allows you to view only those providers accepting new patients.

If you want information regarding your health care provider's background, qualifications and experience, call EHP Customer Service at 800-261-2393.

Access Care Outside the EHP Network

There may be times when you need service outside the network. If you have an emergency, go to the nearest emergency room whether or not that hospital is in- or out-of-network. (For details, review the Emergencies section in this handbook.) For medical conditions that are not serious enough to be an emergency, but that still require prompt/urgent medical attention, your physician may refer you to an urgent care center. Physician visits and diagnostic services and treatment at in- and out-of-network urgent care centers are covered under the PPO plan. (A deductible, co-insurance, or copay may apply.) Only In-network (including the Cigna PPO network) urgent care centers are covered under the EPO plan. (A deductible, co-insurance, or copay may apply.)

If you need to treat a non-urgent condition and you cannot locate an in-network EHP provider or a provider through the Cigna PPO network, you may still be covered. To determine whether specific urgent and non-urgent services are covered out-of-network, or to determine whether your plan has a copay or reimbursement process, review your SPD, which is available through your HR Support Center at 443-997-5400, or your SOB, which is located at **ehp.org**.

Get the Care You Need

Primary Care

Your primary care provider (PCP) is the doctor, physician, or other health care professional that you see for your regular and preventive care. Your PCP is an important part of your health care. Through regular visits, your PCP gets to know you and your health, gives you advice based on everything they know about
you, keeps a record of your health and your medical history, and helps you work with specialists.

Your PCP should be your first line of care and will see you for routine checkups (well-visits) as well as when you are sick or have a minor injury. Even if you need care quickly, your PCP may be able to see you for same or next-day appointments. They can also direct you to an urgent care center when appropriate. As always, in an emergency medical situation, you should go to the nearest medical facility for immediate care.

EPO and PPO Plans: It is not required for EHP members in the EPO and PPO plans to select a PCP, however we encourage all of our members to have one. By selecting a PCP, you will be able to schedule appointments more easily, and you will be more likely to develop a comfortable, familiar relationship with your physician. You can choose a PCP by calling Customer Service at 800-261-2393 or by logging into your HealthLINK@Hopkins member portal.

Specialist Care

Sometimes, an injury, illness or health condition may require care from a doctor with a specialty in a certain area of medicine. You do not need a referral to see a specialist. If you already see a specialist and would like to stay with that doctor, visit **ehp.org/find-a-provider** to see if they are in the EHP network or Cigna PPO network. If you need to find a new provider, you can search this directory.

When you have specialty care, be sure to update your PCP on any changes to your health and treatment, including any new or altered medications. You should authorize your specialist(s) to share your medical records with your PCP and schedule follow-up appointments with your PCP to make sure that all of your treatment is coordinated.

Urgent Care

If you need non-emergent care on the weekend or outside of your PCP's office hours, an urgent care center is a good option. It's best to call your provider's office first to see if they can accommodate you for a same-day or next-day appointment. If you cannot be seen by your PCP and you need care quickly, visit an urgent care center. These centers are typically open in the evenings and on weekends. Examples of non-emergency situations that an urgent care center could handle include:

- Minor broken bone
- Back pain
- Earaches
- Fever
- Sore throats
- Flu and colds
- Frequent urination
- Headaches
- Minor illnesses
- Minor injuries

For minor urgent care concerns, you can also use EHP's 24/7 Telehealth Platform. Connect over video with a provider in minutes, 24/7, from wherever you are. See the Telemedicine Appointments Section for more information.

Emergencies

A medical emergency is when you suddenly feel very sick or have severe pain. If you believe that your health is in serious danger, or you are concerned that you may have experienced serious damage to an organ or part of your body, seek medical care immediately by heading to the nearest hospital Emergency Room or by dialing 9-1-1 for an ambulance. An emergency medical situation is one in which immediate care is needed as the result of a sudden and serious illness or injury. Some examples of a medical emergency are:

- Major injury such as a broken leg or large wound
- Heart attack symptoms: severe chest pain, shortness of breath, sweating, and nausea
- Heavy bleeding
- Bleeding during pregnancy
- Major burn
- Unconsciousness
- Difficulty breathing
- Poisoning
- Severe head pain or dizziness

For treatment of an emergency medical situation as described above, your care will be covered, regardless of whether or not the Emergency Room facility participates in the EHP network or Cigna PPO network. Emergency Room copays will be waived if you are admitted. However, if you go to the Emergency Room for services that are not deemed sudden and serious, payment will not be made. If you have an emergency, remember to inform your PCP within 24 hours to let him or her know what happened.

Hospital Care

Please visit **ehp.org/find-a-provider** to view a list of network hospitals. You can search the EHP Network or Cigna PPO Network for hospitals. When searching, select "Hospital or Facility."

Hospital care follows EHP's prior authorization policy. All EHP members will be able to receive hospital care, but the services covered and the costs associated with that hospital care are unique to your plan. All plans require prior authorization before any inpatient care. Similar to the procedure for services and supplies, prior authorization for inpatient care will be handled by the participating hospital. If the hospital fails to receive prior authorization, then coverage for care, services or supplies may be limited or denied.

Please note that if you go to a hospital for an emergency and are not admitted, you will have to pay an Emergency Room copayment. Your Emergency Room copay is waived if you are admitted. Refer to your SOB to determine your copayment amount.

You are also responsible for notifying EHP of any out-of-network hospitalization within 24 hours. Please call 410-424-4476 or 800-261-2429.

Behavioral Health Care

All EHP plans cover inpatient and outpatient mental health care, as well as care and services for substance use disorder. Visit **ehp.org/find-a-provider** to view a list of network behavioral and mental health providers. On the search page, select "Behavioral Health" under the "Search Type" menu. You can also find a therapist or psychiatrist in the UpLift network by going to **joinuplift.co**. UpLift will match you with providers with available appointments as soon as the next day, and no further out than two weeks. See the Telemedicine Appointments section for more information.

As an EHP member, you will be able to receive hospital care for behavioral health, but the services covered and the costs associated with that hospital care are unique to your plan. All plans require prior authorization before any hospitalization. Similar to services and supplies, prior authorization for this care will be handled by the participating hospital. Services are prior authorized and coordinated through the EHP Behavioral Health Care Coordination program. If they fail to receive prior authorization, then coverage for care, services or supplies may be limited or denied.

Similar to the procedure for standard hospitalization, you are responsible for notifying EHP of any out-of-network behavioral health hospitalization or partial hospitalization. For more information on plan-specific care, or to speak with a clinical care manager, call Mental Health and Substance Use Disorder Services at 800-261-2429.

You are also responsible for notifying EHP of any out-of-network hospitalization within 24 hours. Please call 410-424-4476 or 800-261-2429.

Shop for Health Care Services

The cost for the same health care service can vary widely at different facilities. EHP wants you to know how much you could pay before your appointment. With the ClearCost Health estimator tool, you can price shop for the service you need. Start shopping, start saving.

Employee Access: Visit **ehp.org/benefits** to find the section on the cost estimator. Select your employer group from the drop-down list.

Dependent Access: Visit app.clearcosthealth.com/login and create an account or log in.

Schedule an Appointment

Once you have selected a provider, call their office to set up an appointment. It is always good to check that they participate with EHP when you call the office to schedule your first appointment.

Make sure you carry your EHP member ID card with you to your first, and every, appointment.

If you cannot keep an appointment, please call the doctor's office as soon as possible to cancel or reschedule. If you do not do so, you may be charged a fee.

EHP members want and deserve timely access to quality health care. The Maryland Code of Regulations (COMAR) and the Code of Federal Regulations (CFR) establish clearly defined appointment access standards. All in-network providers must meet these standards when scheduling appointments for members. EHP members have the right to appointments within the following time frames:

Service	Appointment Wait Time (not more than)
History and Physical Exam	90 calendar days
Routine Health Assessment	30 calendar days
Non-urgent (symptomatic)	7 calendar days
Urgent Care	24 hours
Emergency Services	24 hours

Behavioral Health Service	Appointment Wait Time (not more than)
Initial Visits for Routine Care	10 business days
Emergency Services (non-life threatening)	6 hours
Urgent Care	48 hours
Follow up routine care	30 calendar days

EHP's Provider Relations department monitors appointment access standards through quarterly reports. We compare the reports against regulatory and accreditation standards, and will initiate actions as needed when we identify improvement opportunities.

If you believe your providers are not meeting these standards, please call Customer Service to file a complaint.

Telemedicine Appointments

EHP covers telemedicine (video and audio visits) with health care providers. These visits have the same coverage and costs as in-person visits, and the same authorization requirements apply. Telemedicine provided by out-of-network providers is covered and payable under member's out-of-network benefits, if applicable. Telephonic consultation is also covered.

EHP members also have access to our 24/7 telehealth platform. This service allows members to connect with a provider for a general medical visit 24/7 from the comfort of their home or anywhere they may travel in the United States. This service can be used as an alternative if you are unable to see your PCP. Use of this service is intended for common, minor ailments, such as a cough, rash, seasonal allergies, cold and flu symptoms, pink eye, sinus infection, sore throat, and more. This service is for adults and children ages 3 and older. Individuals under the age of 18 must be accompanied by an adult. Access EHP's 24/7 telehealth platform at **ehp.org/virtual-care**.

For behavioral health care, members can use UpLift for virtual appointments. In addition to the behavioral health providers in the EHP and Cigna PPO networks, UpLift offers in-network access to many therapists and psychiatrists. While most appointments are virtual, some providers offer in-person visits. The UpLift platform will match you with providers with availability as soon as the next day, and no further out than two weeks. Visit **ehp.org/uplift** to learn more.

Fill Your Prescriptions

Prescription and Pharmacy Information

Your pharmacy benefits are managed by CVS Caremark. CVS Caremark determines which prescription medications are covered and how they are covered. This information is outlined in a document called a formulary. You can view CVS Caremark's Advanced Control Choice Formulary on the Pharmacy section of **ehp.org**. You can also find more information on your prescription coverage, manage your prescriptions, check order statuses, and view costs and coverage and savings opportunities at **caremark.com**. You will need to register for an account.

The EHP pharmacy network includes more than 64,000 pharmacies nationwide. The network includes most chain retailers and independent pharmacies. Search for a participating network pharmacy near you at **caremark.com**. Registration is required for first time use.

Don't want to go to the pharmacy to get your prescriptions? Try mail order. This service offers a convenient and cost-effective option for obtaining medications you take on an ongoing basis. You can receive up to a 90 day supply of chronic use medications and have these medications delivered to the location of your choice. Mail Order service is provided by CVS Caremark. Refill your prescription online at **caremark.com** or use the Mail Order form at **ehp.org**.

Key Pharmacy Terms

Copay: A fixed fee that you are responsible for when receiving prescriptions. The amount depends on the prescription tier.

Formulary: A list of medications selected for coverage under the pharmacy benefit, based on efficacy, safety, cost-effectiveness, and clinical evidence. You can view your Advanced Control Choice Formulary on the Pharmacy section of **ehp.org**.

Formulary Tier: A coverage classification of a medication. You are covered by the EHP pharmacy benefit which has a four-tier drug benefit. Each tier has a different copay or out-of-pocket expense. Members are responsible for a portion of the cost of their medications.

Quantity Limit: A maximum amount of a certain medication that you are allowed to fill. Only certain medications have quantity limits.

Preferred Formulary Alternative: A medication covered by EHP in a lower tier. These medications, including generics, are as effective as brand-name and higher tier drugs.

Advanced Control Choice Formulary™ and Copay Tiers

Your prescription benefit has a four-tier structure. Your prescription medications fall into one of four tiers. Each tier has a different copay or out-of-pocket expense for which you are responsible.

To determine your copay, formulary status, availability of generic substitute, and preferred formulary alternatives for any of your medications, or to search for a participating pharmacy near you, visit **caremark.com** (registration is required for first use).

Here are the four tiers for your prescription coverage:

- **Tier One: Generic**
  Generic drugs have the lowest out-of-pocket cost for members and are placed on Tier 1. Generic products are listed in the formulary in lowercase italics.
- **Tier Two: Preferred Brand**
  Preferred brand-name drugs have a significant safety or efficacy advantage compared to similar agents. These agents have an intermediate out-of-pocket cost for members. These products are usually placed on Tier 2 and listed in the formulary in all capitals.
- **Tier Three: Non-preferred Brand**
  Non-preferred brand-name drugs do not have a significant, clinically meaningful advantage in terms of effectiveness, safety, and clinical outcomes compared to similar agents. These drugs have higher out-of-pocket costs for members. In most cases, there will be Tier 1 or Tier 2 alternatives for products found in this tier. Non-preferred brand-name drugs covered under the pharmacy benefit are not displayed in the formulary and may process in Tier 3.
- **Tier Four:** Brand Drugs with Generic Substitute (highest copay). This tier includes brand drugs for which a generic equivalent is available, as well as select non-preferred brand drugs.

If you choose a brand-name drug with a generic equivalent, you will be required to pay the highest copay plus the difference in price between the brand and its generic equivalent.

You can use information in the Advanced Control Choice Formulary to help you identify the drugs covered under each therapeutic category. To determine your copay or find a lower-cost generic or preferred brand alternative for a medication, you can check your drug's cost by creating an account at **caremark.com**.

When clinically effective options are available to treat your condition, certain medications may be removed from the list of covered drugs. Your doctor always has the final decision on what medication is right for your condition. Remind your doctor that your benefit plan no longer covers this medication, and you may have to pay the full price. Speak with your doctor to write a new prescription for a covered medication.

Your doctor can view a list of covered drugs and associated tier status on the Advanced Control Choice Formulary. A list of non-covered drugs and the formulary alternatives (preferred options) are also available in the formulary. If you cannot use a formulary medication, your doctor may submit clinical documentation of medical necessity, including treatment failure of covered drugs. Without a prior authorization for medical necessity you may be required to pay the full cost of the medication. Medications that are used for weight loss management are not covered under the selected prescription drug benefit plan. Please refer to your Summary Plan Description (SPD) for full details

The EHP Advanced Control Choice Formulary is subject to change at any time. The formulary is updated on a regular basis, including when new generic or brand-name medications become available and as discontinued drugs are removed from the marketplace.

How to Transfer Prescriptions

To determine if your current pharmacy accepts EHP, you can call the pharmacy or visit **caremark.com** to view a list of in-network pharmacies. You will need to create an account to ensure that you are viewing in-network pharmacies.

If you need to transfer your prescriptions to an in-network pharmacy, here are two options:

1. **Phone:** call the pharmacy you want to start using and ask them to request your prescription from your previous pharmacy. Be sure to tell them the prescription name and any personal information they require.
2. **In store:** bring your prescription bottle and insurance card to the new pharmacy.

Generic Medications

EHP encourages the use of generic medications. Generic drugs are chemically identical to their brand-name counterparts. They are made with the same active ingredients and produce the same effects as their brand-name equivalents. *The Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength, purity, and stability as brand-name drugs.* Also, the FDA requires that all drugs, including generic drugs, be safe and effective.

Specialty Medications

Specialty medications are used to treat complex, long-term conditions. These are medications that may need special storage or have side effects that your health care provider needs to monitor. Some of these medications are covered by your pharmacy benefits and some are covered by your medical benefits.

- Specialty medications covered under medical benefit are either given to you by your provider or taken while your provider is there with you. Some of these medical drugs may require prior authorization and your doctor may ask EHP to approve them.
- Select specialty medications are covered under a new no-cost program called **PrudentRx**. The member cost-share for these medications is a 30% co-insurance, but you can pay **$0** by enrolling in the PrudentRx program.
- Members are eligible for the Prudent Rx program if they take one or more of the medications on the PrudentRx Specialty Drug List. View the specialty medications: **PrudentRx.com/prudentes**. This list represents specialty medications that are currently eligible under the PrudentRx program. The list is subject to change and is updated monthly.

- You must enroll in the Prudent Rx program to be eligible for the $0 copay. If you take one or more of the medications on the PrudentRx Specialty Drug List, you may call PrudentRx at 800-578-4403 to enroll. A trained member advocate will guide you through the process of enrolling you in the program. If you are not enrolled in the PrudentRx program, the medications are subject to a 30% co-insurance.
- Medications on the PrudentRx Specialty Drug List must only be obtained from CVS Specialty Pharmacies and Publix Pharmacies in Florida.

For more information about the PrudentRx program and select pharmacies, visit **ehp.org**.

Prior Authorization and Quantity Limits

Certain medications require prior authorization before coverage is approved. These drugs are subject to specific criteria approved by physicians and pharmacists on the EHP Pharmacy and Therapeutics Committee. Established criteria are based on medical literature, physician expert opinion, and FDA-approved labeling information.

Certain prescription medications have specific dispensing limitations for quantity and maximum dose. These dispensing limitations are based on generally accepted guidelines, drug label information approved by the FDA, current medical literature, and input from a committee of physicians and pharmacists. The three types of quantity limits are:

- Coverage limited to one dose per day for drugs that are approved for once-daily dosing
- Coverage limited to a specific number of units over a defined time frame
- Coverage limited to approved maximum daily dosage

When medically necessary, an exception to quantity limits can be requested. To see a list of drugs in your EHP plan that have quantity limitations or that require prior authorization, visit the pharmacy section at **ehp.org**. This list is subject to change without notice.

Evaluation of New Technology, Drugs, and Benefits

EHP's written process for evaluating new technology and the new application of existing technology for inclusion in its benefits plans includes the evaluation of medical procedures, behavioral health procedures, pharmaceuticals, and devices. In considering these changes, EHP reviews scientific literature and solicits input from relevant specialists and professionals who have expertise in the technology.

Stay Healthy

Being healthy requires more than great care from your providers. EHP encourages our members to focus on healthy lifestyle habits and proper self-management. We have a variety of services to support you. These benefits are offered to you at no cost.

No matter where you are on your health journey, your EHP care team is ready to help you do more for your health. Together, one small step at a time, you can achieve big change.

Our health programs and services are voluntary. EHP may identify and enroll members with certain conditions or needs, but you are under no obligation to participate. You can also request our services if you believe they would help you. Please contact us Monday through Friday, 8 a.m. to 5 p.m. by calling 800-557-6916 or emailing **caremanagement@jhhp.org** to opt in or opt out of services. Any messages received after business hours will be addressed the following business day.

Your EHP Care Team

Care Managers are registered nurses and licensed clinical social workers who serve as advocates and partner with you and your health care providers to coordinate your care. They offer support, guidance and encouragement to help you achieve your best health. Care Management services are voluntary and provided at no cost to you. Our Care Management model promotes prevention, identifies health risks early and supports your active participation in your care plan.

- Assess your overall wellness and personal health needs
- Coordinate appropriate health care services, treatments and supplies
- Help you build the skills and confidence to manage your health conditions effectively
- Assist with referrals to specialty providers and community resources
- Ensure you receive the right care, in the right place, at the right time

Licensed Clinical Social Workers provide caring support for members who may be dealing with mental health or substance use concerns. They work with you and your care team to make sure you have the help and resources you need to feel your best.

Preventive Health

Care managers provide care coordination and connect at-risk members with resources to help stabilize their health and prevent the development of more serious care needs. The Care Management team works closely with health care providers to address gaps in care and support members in managing their own health and wellness.

Care managers can also offer guidance to help you stay on track with preventive care — making sure you are up to date on screenings, annual checkups and immunizations. They may recommend EHP health education classes and resources to help you learn more about your health. You may be contacted by a care manager who can guide you through a new diagnosis, coordinate care with your providers and help you with getting the most out of your health plan benefits

Care Management Services

Care Management is a free, voluntary program designed to help you stay healthy and manage your care more easily. If you have complex health needs or are at risk for hospital or ER visits, we're here to help.

Your Care Management team works one-on-one with you and your doctors to make sure you get the right care at the right time. You may work with a registered nurse or licensed clinical social worker who can explain a new diagnosis, help you manage a chronic condition and connect you with helpful resources.

Services include:

- Telephonic outreach
- Health education
- Reminders for appointments and screenings
- Medication review and management
- Coordination of health care services and supplies
- Support to help you meet your health care goals

For more information or to request or decline services, call 800-557-6916,
Monday – Friday, 8 a.m. – 5 p.m.
Email: caremanagement@jhhp.org

Health Education

There is always something that we can learn about our health. With only limited time at our doctor visits, we may not get to discuss our health and conditions as much as we would like.

EHP has a variety of interactive health education programs to give you information and tips and tools to better manage your health. Learn more about specific health conditions in a supportive group environment. Participants share challenges and successes to help other members.

Program topics include:

- Newborn care
- Diabetes and prediabetes
- Managing asthma
- Heart disease
- Weight management
- Healthy sleep habits
- Anxiety and stress management

Programs are offered throughout the year. View all programs, dates and times and register at **ehp.org** under Health and Wellness Classes. Learn more or sign up for a program by calling 800-957-9760 or emailing healtheducation@jhhp.org.

Complex Care

If you are ever faced with a serious medical event, complex medical conditions, or several ongoing conditions, our care management team is here to help you. Your care manager will take time to understand your health needs, work with you to create a personal plan for managing your care and ensure that you get the right care.

Services include:

- Telephonic outreach
- Health education
- Reminders for appointments and screenings
- Medication review and management
- Coordination of health care services and supplies
- Partnership with your health care providers
- Coordination with social and community resources

For more information or to request or decline of services, call 800-557-6916, Monday – Friday, 8 a.m. – 5 p.m, or email caremanagement@jhhp.org

Transition of Care

Care Managers are here to help you navigate the health care system after a hospital stay, emergency room visit, new diagnosis, or major life change. Your care manager will work closely with you to coordinate follow-up appointments, ensure smooth communication with your providers and specialists, and help remove any barriers that may stand in the way of your care. Together, you'll create a plan to keep your health on track and prevent future emergency department visits or further health complications.

For more information or to request or decline services, call 800-557-6916, Monday – Friday, 8 a.m. – 5 p.m., or email caremanagement@jhhp.org.

Maternal/Child Health

EHP wants you to have a healthy pregnancy and delivery. Your benefits include no-cost support to guide you through your pregnancy and to help with any advanced care your baby may need. We'll provide education, answer your questions, and connect you with resources every step of the way. If your pregnancy requires extra support, one of our care managers will work one-on-one with you.

Get an extra level of support during your pregnancy by partnering with a care manager who specializes in maternity care coordination.

Through our pregnancy support, we make sure you are prepared for every stage of the journey with:

Educational Materials

We provide all pregnant moms with educational materials that help you learn how to stay healthy through your pregnancy.

Regular Check-ins

We will communicate with you to ensure that you are receiving the proper care, including having your postpartum visit.

Care Management

We partner with you and your health care providers, answer your questions, and assist you with eating well, exercise, and other personal health needs.

NICU

If your baby is admitted to the Neonatal Intensive Care Unit (NICU), we'll make sure you understand their treatment plan and feel confident caring for them after they come home. Care Management services for NICU graduates are provided by ProgenyHealth during your baby's first year of life. ProgenyHealth's team of neonatologists, pediatricians, and neonatal nurse care managers work closely with the NICU facility to promote healthy outcomes for premature and medically complex newborns.

Your ProgenyHealth care manager will help with discharge planning, coordinate care with your child's providers, and guide you in using your benefits. You'll receive educational materials, referrals to helpful community resources, and assistance arranging in-home services or special equipment if needed.

After your child's first year, you can continue partnering with an EHP care manager who specializes in pediatric care coordination. We'll support you as your child grows and help manage any ongoing or complex health needs through every stage of development.

For more information or to request or decline services, call 800-557-6916, Monday – Friday, 8 a.m. – 5 p.m., or email caremanagement@jhhp.org

Behavioral Health Care Coordination

When you have a mental health or substance misuse concern, you can get confidential support from a licensed clinical social worker. A behavioral health clinician can:

- Teach you about your mental well-being
- Discuss your treatment needs
- Help you connect to a mental health or substance abuse specialist
- Coordinate your care between providers
- Offer resources to help you understand and manage your medications
- Important: If you are having an emergency or behavioral health crisis, call **911** now or contact the National Suicide Prevention Lifeline at **988**.

For more information or to request or decline services, call 800-557-6916, Monday – Friday, 8 a.m. – 5 p.m., or email caremanagement@jhhp.org

Utilization Management

EHP is committed to maintaining the health and wellness of all our members. Utilization Management (UM) ensures that care is provided at the right time and in the right setting. The UM department evaluates requests for services for medical care, mental health treatment, and substance use disorder treatment, based upon appropriate clinical criteria or guidelines and local health care delivery options. This, often times, requires prior authorization by your provider for certain services and the review of requests for authorization for elective hospital admissions. All review decisions are based upon appropriate care and service and existence of coverage. Registered nurses and medical directors make the UM decisions.

Plan Perks

EHP is always looking for ways to improve your health. With Plan Perks, we find products and services that support our goal of helping you live your healthiest life. Then, we give you free or discounted use of them. Learn more about these Perks at **ehp.org/plan-perks**.

BurnAlong

Perk: $39 yearly subscription

Get—and stay—fit, no matter where you are with BurnAlong, a new cutting-edge fitness and wellness program. BurnAlong offers more than 1,000 classes in 30 categories. Stream unlimited classes on your own or with colleagues and friends in a private group setting whenever you want, wherever you want, for just $39 for an entire year! You can access the classes on your computer, tablet or phone, with the option to cast it to your T.V.

Steps:

- Go to **well.burnalong.com/register**
- Put in your information and select annual plan
- Put in discount code **ANNUAL81**

Understand the Costs and Rules for Using Your Plan

Your Financial Responsibility

As a member, EHP helps you pay for the health care you need. Still, you have certain financial responsibilities as a plan member. These out-of-pocket costs include copayments, co-insurance, deductible, and expenses for non-covered benefits.

- You must meet your deductible, which is the amount you must pay within the plan year, before EHP begins to pay benefits. Your Schedule of Benefits (SOB) or Summary Plan Description (SPD) will advise if you have a deductible. Certain benefits, such as preventive care services, are covered by EHP, regardless of whether you have met your deductible.
- Your copays are fixed fees that you pay at the time of service. Copays may differ depending on the type of provider you see, the type of service, or the prescription tier.
- Your co-insurance amounts are percentages of a total health care cost. Some benefits have a copay and some have co-insurance. You will be billed for your co-insurance amount, and you pay them directly to your provider.

Prior Authorization: Getting Approvals for Services

Prior authorization is required for certain medical services and supplies. Your Schedule of Benefits and outpatient referral guidelines indicate which services, supplies, or medications require prior authorization. All prior authorization requests are coordinated through your physician's office. If they fail to receive prior authorization, then coverage for care, services or supplies may be limited or denied. Any costs for denied services that were the result of an in-network provider failing to receive prior authorization are not your responsibility.

What Happens if Your Doctor Leaves the EHP or Cigna PPO Network

In some cases, a provider may leave the EHP network or the Cigna PPO network. If this happens, you can select another doctor from our provider directory (available at **ehp.org**). If you choose to stay with your provider, please be aware that your financial responsibilities will change. Your benefits will be covered at the out-of-network level.

How to File a Claim

To submit a reimbursement, create or log into your member account. Click "Member Login" at the top of **ehp.org**.

Once inside your member portal, go to the "My Health Plan" menu and select "Claims Reimbursement Form." Select the "Member Reimbursement Form" link. Note: You can also check the status of previously submitted claims on this page. If you have dependents on your account, a window with the dependents will show. Select the appropriate member. In the Claims Reimbursement Form, fill out all the required fields and include any supplemental information. Add your proof of payment as an attachment.

Most plan members have 12 months from the date of service to submit claims for reimbursement.

File an Appeal or Complaint

Appeals

You may appeal clinical decisions in whole or in part. Appeals are reviewed by a peer clinician to the ordering provider.

A member or an authorized representative may appeal or request a review in writing to EHP. Urgent appeals may be accepted over the phone. **Appeals must be received within 180 days of the date of the denial or all rights to appeal are lost.** If you have not received the services that were denied, you will receive an appeal determination within 15 days. If you have already received the services that were denied, you will receive an appeal determination within 30 days. If your appeal is considered urgent, you will receive a determination within 36 hours.

Mail appeals to:

Employer Health Programs
Attn: Appeals Department
7231 Parkway Dr., Suite 100
Hanover, MD 21076

For urgent appeals, please call or fax:

Phone number: 410-762-5383
Fax number: 410-424-2701

The above is only a brief summary of the appeal rules. The complete appeal rules that you must follow are contained in your Summary Plan Description.

Complaints

EHP appreciates your feedback and would like to know if you ever have a complaint about our services or services received by a network provider. We accept both written and verbal feedback.

Complaints can be mailed to:

Employer Health Programs
Attn: Member Complaints and Grievances
7231 Parkway Dr., Suite 100
Hanover, MD 21076

Contact:

Customer Service number: 800-261-2393
Fax number: 410-424-2701

Know Your Rights and Responsibilities

We value you as a member of our EHP health care family. As a member, you have the following rights and responsibilities:

You have the right to:

- Be treated with respect for your dignity and privacy
- Discuss all appropriate treatment options for a condition regardless of cost or benefit coverage
- Receive information, including information on treatment options and alternatives, in a manner you can understand
- Participate with providers in decisions regarding your health care, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of your medical records and request that they be amended or corrected as allowed
- Exercise your rights and to know that the exercise of those rights will not adversely affect the way that EHP or our providers treat you
- File complaints, appeals, and grievances about the organization or the care we provide (See page 25)
- Request that ongoing benefits be continued during appeals (although you may have to pay for the continued benefits if our decision is upheld in the appeal)
- Receive a second opinion from another provider in EHP's network if you disagree with your provider's opinion about the services that you need. Contact us at 800-261-2393 for help with this
- Receive other information about us such as how we are managed. You may request this information by calling 800-261-2393
- Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- Make recommendations regarding the organization's member rights and responsibilities policy

You have the responsibility to:

- Carry your membership card with you at all times and know your eligibility status with EHP. If you lose your card, you can obtain a new one by calling Customer Service, or from your HealthLINK@Hopkins account
- Follow your plan's prior authorization guidelines and polices
- Cancel appointments if you are unable to keep them
- Pay applicable copay, co-insurance, and deductible at the time of service
- Report any other health insurance coverage to your provider and to EHP
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care
- Follow plans and instructions for care that you have agreed to with your provider
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

How EHP Protects Your Privacy

EHP is committed to respecting your privacy. The purpose of this information is to describe how your Protected Health Information (PHI) may be used and disclosed and how you can get access to this information. Please review it carefully. EHP's official **Notice of Privacy Practices (NPP)** fully describes:

1. EHP's routine use and disclosure of PHI
2. Use of authorizations
3. Access to PHI

Please take time to review your NPP. It is available at **ehp.org** or by calling Customer Service. If you have any questions regarding the NPP content, please call the Johns Hopkins Privacy Officer at 410-614-9900.

Health information means information that identifies you and tells about your medical history and provision of health care to you. It also includes information about payment for health care services, such as your billing records. By law, we are required to:

1. Ensure that your health information is protected
2. Provide to you the NPP describing our responsibilities and privacy practices with respect to your health information
3. Follow the terms of the Notice that is currently in effect

Information collected on race, ethnicity, language, gender identity, and sexual orientation is considered confidential and protected health information. We treat this data with the same level of privacy as all other medical records. We will use this information to enhance our services and better understand the needs of our members. This data is only shared with our health care provider partners in an effort to improve your health. This data will not be used to determine your eligibility for benefits or the cost of your health care.

In addition, EHP has implemented internal policies and procedures which address **how we protect oral, written, and electronic use of PHI**. For your protection, EHP always verifies the identities of both the member and the requestor prior to responding to a request for a member's PHI. Examples of such contact are:

1. Questions about your treatment or payment activities
2. Requests to look at, copy, or amend your Plan records
3. Requests to obtain a list of Plan disclosures of your health information

EHP secures and limits access to all hardcopy and electronic files. All electronic data is password protected. EHP limits workforce member access to all hardcopy and electronic files. Internal controls are in place to ensure that only those workforce members with a "need to know" have access to information required to perform their specific job function. All workforce members are required to only utilize and/or access the "minimum necessary" information.

EHP takes disclosure of PHI to plan sponsors (employers) very seriously. Our first duty is to protect your privacy. EHP has placed very specific controls on your information to ensure that your information is protected. We will only release your health information to the plan sponsor for administrative purposes if certain provisions have been added to EHP to protect the privacy of your health information, and the sponsor agrees to comply with the provisions. EHP will not disclose PHI to the plan sponsor for employment-related actions, or for decisions in connection with any other benefit or benefit plan of the sponsor, unless the individual signs an authorization permitting such disclosure. For more information on authorizations or to download the forms required to permit an authorization of disclosure, visit **ehp.org**.

Preventing Health Care Fraud and Abuse

EHP wants to find and stop health care fraud, which is any dishonest act that a person commits on behalf of someone else that results in benefits to which he/she is not entitled. Some examples of health care fraud are:

- Using someone else's EHP insurance card to get health care services
- Loaning your EHP insurance card to another person so that they can receive health care services
- Sending bills for equipment or services you never received

EHP takes its responsibility to protect your "right to report" seriously. No EHP employee may threaten, coerce, harass, retaliate, or discriminate against any individual who reports a compliance concern. To support this effort, EHP has enacted zero-tolerance policies and annually trains all personnel on their obligation to maintain the highest integrity when handling compliance related matters. Any individual who reports a compliance concern has the right to remain nameless, and EHP commits to enforcing this right. Johns Hopkins Health Plans Program and Payment Integrity investigates all charges of actual or suspected health care fraud. If you believe someone is committing fraud against EHP, please report the act to Program and Payment Integrity at 410-424-4971 or FWA@jhhp.org. You can also write to:

Johns Hopkins Health Plans Program and Payment Integrity
Attn: Fraud, Waste and Abuse
7231 Parkway Dr., Suite 100
Hanover, MD 21076

Fax: 410-424-2708

For additional information including how you can help reduce health care fraud, visit **ehp.org**.

Get Help

Important Contact Information

Name	Address	Phone	Fax
EHP Customer Service (M-F, 8 a.m.–5 p.m.) **www.ehp.org**	7231 Parkway Dr. Suite 100 Hanover, MD 21076	800-261-2393 410-424-4450	410-424-4895
Mental Health and Substance Use Disorder Services	7231 Parkway Dr. Suite 100 Hanover, MD 21076	800-261-2429 410-424-4476	410-424-4891
EHP Care Management	7231 Parkway Dr. Suite 100 Hanover, MD 21076	800-557-6916	410-424-4890
Pharmacy CVS/Caremark: www.caremark.com	For pharmacy customer service support, please call EHP Customer Service at the numbers listed above or call the number on the back of your ID card. Information regarding Pharmacy benefit is also available at ehp.org/pharmacy.		
Cigna PPO Network	For information or questions about the nationwide Cigna PPO network, please call EHP Customer Service at the numbers listed above.		

Request an Interpreter

Many of our physicians and hospitals have interpreter services onsite. Please let your physician know if you need an interpreter, and they will arrange one for you. EHP provides language and American Sign Language interpreters for medical appointments when your physician cannot provide this service. To request an interpreter, please call Customer Service at 800-261-2393. A TTY line is also available to all members between 8 a.m. and 5 p.m., Monday through Friday. The Maryland Relay Operator telephone number is 800-201-7165.

You can also request alternative formats for certain EHP forms and documents. Alternative formats include non-English languages, large print, audio and other forms of accessible electronic formats.

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Dr., Suite 100
Hanover, MD 21076

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