Johns Hopkins US Family Health Plan

2025 Member Handbook

JOHNS HOPKINS
HEALTH PLANS

Quick Reference

Medical Emergencies

For life-threatening emergency treatment . . . . . Call 911

To arrange for emergency or urgent care

In area . . . . . Call your PCM

Out of area . . . . . Call your PCM

Out of country . . . . . Notify Customer Service Department within 7 days of return

Member Information and Assistance

Johns Hopkins US Family Health Plan

7231 Parkway Drive, Suite 100, Hanover, MD 21076 . . . . . 800-80-USFHP (800-808-7347)

Benefits Questions

Customer Service . . . . . 410-424-4528 or 800-808-7347 or usfhpcustomerservice@jhhp.org

Billing . . . . . 410-424-4835 or 888-717-8282 or usfhpcustomerservice@jhhp.org

Coordination of Benefits 410-424-4716

Discounted Dental Plan:

Concordia Advantage Network 800-332-0366

Care Management 800-557-6916

Utilization Management . . . . . 410-424-4480 or 800-261-2421

Enrollment Department 410-424-4528 or 800-808-7347 or usfhpcustomerservice@jhhp.org

Pharmacy Services 800-808-7347

Mail-order Pharmacy in Maryland 410-235-2128

Mail-order pharmacy outside of Maryland. 800-345-1985

Website . . . . . **www.hopkinsusfhp.org**

After-Hours Services

Call our Nurse Line – Answers for your health questions 24 hours a day, at 866-444-3008. Or call your Primary Care Provider's after-hours service.

Virtual On Demand – Johns Hopkins OnDemand Virtual Care (weekdays from 6 p.m. to 8 a.m. and on the weekends). Visit hopkinsmedicine.org/ondemand or download the app.

Behavioral Health / Substance Abuse Services

Johns Hopkins Health Plans-Behavioral Health Utilization Department 410-424-4830

Out of area 888-281-3186

Defense Enrollment Eligibility Reporting System (DEERS)

Defense Manpower Data Center Support Office

Attention: COA, 400 Gigling Road, Seaside, CA 93955-6771

Toll Free . . . . . 800-538-9552 FAX: 800-336-4416

Website . . . . . **www.tricare.mil/DEERS**

Table of Contents

2025 Member Handbook

Johns Hopkins US Family Health Plan

Welcome

to the Johns Hopkins US Family Health Plan for retirees and their family members and active-duty family members of the uniformed services. This Member Handbook provides you with the information you will need to get the most from the Plan and to ensure that you know the best way to obtain the services and benefits.

New to the Johns Hopkins US Family Health Plan?

You may have questions and concerns regarding various aspects of your coverage and how the Plan works. Our highly trained customer service representatives are ready to answer your questions, help you locate a primary care provider or a specialist, or provide other assistance you might need. We are available Monday through Friday
8:00 a.m. to 4:30 p.m.

Telephone:
410-424-4528 or toll free, 800-808-7347

E-mail:
usfhpcustomerservice@jhhp.org

Read Your Handbook Carefully

The *Member Handbook* is a summary of eligibility requirements, medical coverage, co-payments, definition of terms, exclusions, and other provisions of the USFHP.

Please note: This handbook is only as current as the date of publication and is subject to change without notice. The *Member Handbook* is also available on our website and should be used as an additional resource. The handbook is located on the home page at the following address:

hopkinsusfhp.org

Updates are also provided to members by individual mailings or in *The Patriot Life*, the quarterly member newsletter.

Johns Hopkins USFHP

Johns Hopkins USFHP or the Plan is a Department of Defense (DoD) sponsored program that delivers TRICARE Prime® benefits to retirees and their family members, active-duty family members and survivors of the uniformed services, including the Army, Navy, Marine Corps, Air Force, Space Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration (NOAA).

Johns Hopkins USFHP's extensive provider network offers many primary care options throughout its service area. In Maryland and the Washington D.C. area, Johns Hopkins Community Physicians (JHCP) is the largest primary care provider group, featuring more than 400 physicians and other health care professionals. JHCP offers the full range of primary care services and some specialty services. Some locations also offer additional onsite services, including pharmacy, labs, X-ray, ophthalmology and optometry. For all USFHP members, specialty care is available by referral to specialists in the Johns Hopkins Health System or the Plan's extensive network.

Long History with the Uniformed Services

Johns Hopkins' history of providing health care to the military began when seven U.S. Public Health Service Hospitals were transferred to private health care entities with the stipulation that they continue to care for the uniformed services beneficiaries through their federal designation as Uniformed Services Treatment Facilities. Following the closure of the Baltimore U.S. Public Health Service Hospital, the Wyman Park Health System was established (1982) and was subsequently acquired by the Johns Hopkins Health System (1986).

In 1993 the DoD reorganized these facilities into the Uniformed Services Family Health Plan. It was the first DoD-sponsored, full-risk, managed health care plan.

The USFHP has been serving military families for more than 40 years and is a part of the military health system known as TRICARE.

How the Plan Works

Johns Hopkins USFHP is a managed care plan, designed to provide comprehensive TRICARE Prime medical benefits to enrolled individuals at a low out-of-pocket cost. A managed care plan is an organized system of health care delivery that relies on a primary care manager (PCM)—a pediatrician, family practitioner or internist—to arrange for all of your health care needs with specific providers and hospitals. Payment for these services is handled by the Plan. Full coverage for covered benefits is available only from Plan providers except during a medical emergency. There are no claim forms when Plan-approved providers are used.

Because the Plan provides or arranges for your care and pays the cost of all authorized services (less any applicable co-payments/cost-shares), every effort will be made to provide efficient and effective delivery of health care services.

Get Started With USFHP

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

1. Sign up for your member portal

HealthLINK@Hopkins is a secure member portal where each enrolled family member can keep track of their own health care. View your personal health record, review your benefit coverage, change your primary care doctor, also called your primary care manager (PCM), search for providers and more. You can also self-serve many Customer Service questions through your member portal by visiting **hopkinsusfhp.org**. Under "I'm a Member" click "Member Login." Under "First Time Logging In?" click "Member Register." Fill in your member ID number, name, birth date, gender and zip code, then click "Next".

2. Schedule a well-visit with your PCM

Your primary care manager is an important part of your health care. Start by contacting your PCM to schedule a well-visit (checkup). We encourage you to schedule this appointment within 30 days of becoming a new member. This will allow your provider to learn about your health and guide you for further care. Your new PCM will also coordinate your referrals.

You have access to a fully accredited network of more than 26,000 primary care and specialty physicians, ensuring you can find care and services near you. If you are currently receiving medical services outside the Johns Hopkins US Family Health Plan network, you will need to change to Plan-approved providers. Your new primary care office will assist you in transferring your records to the Plan. Remember that in order to see a specialist or other type of provider, you must obtain a referral from your PCM.

With our online search tool, you can find a provider by name, search for a location convenient to you and filter by preferences. Go to **hopkinsusfhp.org**. Under "I'm a Member" click "Find a Doctor or Facility." If you want more information regarding a health care practitioner's background, qualifications and experience, call Customer Service at 410-424-4528 or toll-free at 800-808-7347.

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. USFHP 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: **hopkinsusfhp.org/health-and-wellness.**

Bonus: Visit the New Member page of our website for videos to help you understand and use your plan: **hopkinsusfhp.org/new-member-information**

Learn About Your Coverage

View Benefits and Costs

Our website provides detailed information about your covered benefits, enrollment fees and applicable cost shares. View your benefits at **hopkinsusfhp.org/my-benefits**.

Explanation of Benefits (EOB)

After you receive health care services, we will mail you an EOB that outlines exactly which services your provider billed, what has been paid and at what rate, what has been denied and why, and what payment, if any, is your responsibility.

Claim #: 919593761			Paid Date: 11/22/2023							
Date of Service	Billed Amount 1	Allowed Amount 2	Above Maximum 3	Not Covered 4	Deductible 5	Copay/ Coinsurance 6	Other Ins Paid 7	Member Liability 8	Paid Amount 9	Remarks 10
10/01/23-10/01/23	250.00	96.70	153.30	0.00	0.00	25.00	0.00	25.00	71.70	
PROVIDER SERVICE										
TOTALS			153.30	0.00	0.00	25.00	0.00	25.00		
								Provider May Bill You: 25.00		

1. Billed Amount: This is the amount the doctor or facility charged for the service(s) that you received.
2. Allowed Amount: This is the maximum amount USFHP 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.
3. Above Maximum: The Billed Amount minus the Allowed Amount.
4. Not Covered: The amount that will not be considered for payment.
5. Deductible: The amount that you must pay within the plan year before USFHP begins to pay benefits. This applies to the Point of Service option.
6. Copay/Co-insurance: The fixed fee you must pay at the time of service or the percentage of medical costs that you share with USFHP.
7. Other Ins Paid: The amount another health insurance carrier pays as your primary coverage if you have secondary insurance (or Other Health Insurance (OHI).
8. Member Liability: The amount that you are responsible for paying to the provider of service.
9. Paid Amount: Amount that USFHP has paid to the provider for the service(s) that you received.
10. Remarks: Additional information about aspects of the EOB.

Find It Online

The USFHP website (**hopkinsusfhp.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
- View coverage and cost share information
- Access and download forms
- Learn about available health and wellness services

Customer Service

We also have a specially trained staff of customer service representatives available to you between 8 a.m. and 4:30 p.m., Monday through Friday. You may reach a representative by calling 410-424-4528 or toll-free at 800-808-7347.

Interpreter Services

Many of our physicians and hospitals have on-site interpreting services. To request an interpreter, please call Customer Service at 800-808-7347. Assistance for the hearing impaired can be accessed through ***Maryland Relay*** by dialing 7-1-1 or 800-735-2258.

New to The Plan? Here's How It Works With USFHP

JAN 1

Your coverage begins

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 PCM, request a new ID card, and more.

Preventive Care

Schedule your preventive care

You get these services at no extra charge when you see an in-network provider:

- Preventive visits
- Routine physical exam
- Routine eye exam

OnDemand

Get any additional care you need

If you need to see a specialist, you will need a referral from your PCM. Use Johns Hopkins OnDemand Virtual Care or use an urgent care center for when you are not able to see your PCM. Use the emergency room for sudden and severe injuries and illnesses.

Walgreens

Get your prescriptions from Walgreens Home Delivery

Register to have chronic or reoccurring medications mailed to your home.

Copay/ Co-insurance

Pay your share

While many services are $0, some require a cost share (copay or co-insurance). This is usually paid at the time of the visit.

Out-of-Pocket

Catastrophic Loss Protection Benefit

You have a catastrophic cap for health care costs. This means there is a limit to your out-of-pocket expenses.

DEC 31

End of plan year

Member ID Card Overview

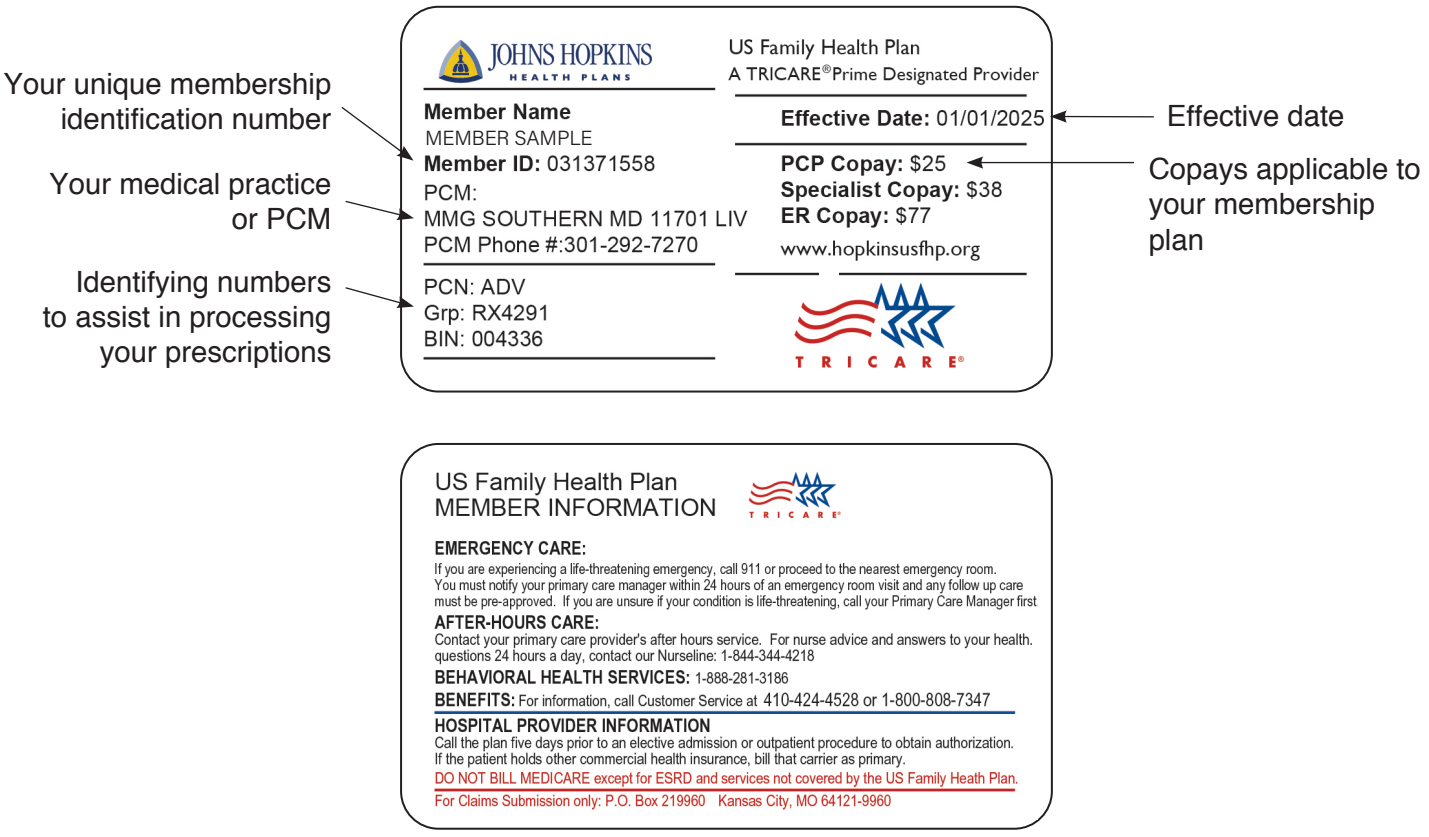
Your Johns Hopkins USFHP member ID card will be mailed to you from the card vendor, separately from your welcome kit. This card provides important information about your Plan membership, relating to coverage for primary care, specialty care, pharmacy benefits and other covered benefits. Additionally, your card provides information about copayments and important telephone numbers, and will authorize you to receive services under the Plan. (See below for details.)

Please carry your card with you at all times and show it at each office visit. If you also have Medicare, please inform your provider that Johns Hopkins USFHP is your primary coverage (see page 25 for more information on Medicare and USFHP).

If your membership ID card gets lost or damaged, you may request a new ID card and print out a temporary card at HealthLINK at Hopkins. You may also contact Customer Service at 410-424-4528 or 800-808-7347, Monday through Friday from 8 a.m. to 4:30 p.m.

SAMPLE ID CARD

(Your actual card may appear slightly different)



The back of your membership card has information for obtaining care. It also gives health care providers information on how to process your claims. Please remember to carry this membership card with you at all times.

The Role of Your Primary Care Manager

As a member of the Plan, you will establish a relationship with a USFHP primary care manager (PCM) who will get to know you, your medical history and your individual health care needs. Our primary care managers are trained in family practice, internal medicine or pediatrics.

Your PCM sees you for all of your routine health needs, monitors the medications you receive, orders tests or special services like physical therapy and maintains your medical records. If you have a complex health condition, your PCM may refer you to one of Johns Hopkins USFHP's many qualified specialists. Your PCM and the Plan specialist will work together as a team to meet your health care needs.

If You Need Specialty Care

To see a specialist or other type of provider, you must obtain a referral from your PCM. The only exceptions are:

- Life-threatening medical emergencies
- Routine annual vision screening exams

Your PCM will choose an appropriate specialist for your care. If, at the time you enroll, you are under the care of a medical specialist who practices outside the Johns Hopkins network, your PCM may transfer your specialty care to a Plan provider. Every effort will be made to ensure that there is continuity in your care. Each time you choose to see a non-Plan provider for a covered service in a non-emergency situation, the service(s) will be paid under the point of service (POS) provision. Please see page 11 for a full explanation of the POS benefit.

If You Are Admitted to a Hospital

If you require hospitalization, your PCM or specialist will make the necessary arrangements for you. Inpatient care will be provided at any of our participating hospitals. Your hospital care will be coordinated by your PCM or another Plan provider. Emergency care will be covered at any hospital.

Note: If you are admitted to a hospital as an emergency, your PCM must be notified as soon as possible or the next business day.

Choosing Your Primary Care Manager

The first and most important decision you will make is the selection of a primary care manager. Each enrollee in your family should select a PCM with whom he or she is comfortable. Family members do not need to select the same PCM, and their selections may be changed upon request.

You can locate primary care managers (PCMs) by visiting **hopkinsusfhp.org** and click on Find a Doctor. This feature allows you to search for a doctor by city, state, field of practice and much more. Be sure to search for a PCM by choosing, family practitioners, pediatricians, internists and nurse practitioners.

If you don't have access to a computer, call Customer Service at 410-424-4528 or toll-free at 800-808-7347 for assistance.

Hospital Services

The Plan provides a comprehensive range of hospital benefits with no dollar or day limit when hospitalization occurs under the care of a Plan provider. There is a $193 co-payment per admission fee for retirees and their family members. Active-duty families and retirees with current Medicare Part B are not subject to the co-payment. All medically necessary services are covered, including:

- Semiprivate room accommodations (a private room may be covered if a Plan provider determines it is medically necessary)
- Specialized care units, such as intensive care or cardiac care units
- Physician services related to medical treatment or surgery
- General nursing services
- Operating room, anesthesia and supplies
- Prescribed inpatient drugs

Accessibility of Services

Service	Appointment Time (not more then)
Well Patient	Four weeks
Specialist visit	Four weeks
Routine Care	One week
Urgent Care	24 hours
Office Visit (wait time)	30 minutes

Johns Hopkins USFHP members are entitled to timely access to quality health care. The TRICARE Operations Manual (TOM) 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. USFHP member access standards are listed below.

USFHP's Provider Relations department monitors appointment access standards through quarterly reports. The Plan compares 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.

Emergency Care

The Plan covers emergency care for sudden and unexpected onset of life-, limb-, or sight-threatening conditions requiring immediate attention, even when you are traveling outside the Plan area.
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 other part of your body, seek medical care immediately by going to the nearest emergency room or by dialing 9-1-1 for an ambulance. Some examples of a medical emergency are:

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

Members who receive emergency care for non life-threatening situations without a referral may be responsible for the cost of the non-emergent care. If you receive emergency care when away from home, the Plan will review your claim and, if the care was medically necessary, pay emergency benefits directly to the providers. Any follow-up care must be coordinated through your PCM. If you are unsure if your condition is life-threatening, call your PCM or the USFHP NurseLine for guidance at anytime, 24 hours a day, seven days a week.

At the time of the ER visit, retirees without Medicare Part B and their family members will be asked to pay a $77 co-payment. If they are later admitted as an inpatient, only the inpatient co-payment applies (and the $77 co-payment is waived). Active-duty family members and retirees and their family members with Medicare Part B do not pay co-payments for emergency room visits.
If you require follow-up care such as removal of stitches or X-rays after your ER visit, your PCM will provide or coordinate your care. Do not return to the emergency room for follow-up care unless your PCM refers you there. Reduced or no payment will be made for unauthorized follow-up care.

After-Hours Services

24-Hour Services For USFHP Members

NurseLine

USFHP members can call the USFHP NurseLine telephone number to speak directly to a registered nurse any time of the day or night. Nurses will answer questions and provide information about your medical concerns.

USFHP NurseLine: 844-344-4218

Nurse Chat Line

For members preferring to use the Internet to obtain general health information, Nurse Chat provides live access to registered nurses at **nurselinechat.com/jhhcusfhp**.

Johns Hopkins OnDemand Virtual Care

Talk to a health care provider from the convenience of your mobile device or computer. Connect from anywhere in the U.S., no appointments needed. Providers can diagnose and prescribe medications for minor care concerns such as colds, rashes and pinkeye.

Service is available all day to members on weekdays from 6 p.m. to 8 a.m. and all day on the weekends. Visit **hopkinsmedicine.org/ondemand** or download the app.

MedlinePlus®

MedlinePlus is the National Institutes of Health's Web site for patients and their families and friends. Produced by the National Library of Medicine, the world's largest medical library, it brings you information about diseases, conditions, and wellness issues in language you can understand. MedlinePlus offers reliable, up-to-date health information, anytime, anywhere, for free. The use of this site is not intended to be a substitute for health care information provided by the plan, but may be used as a resource to supplement the plan's health care information.

You can use MedlinePlus to learn about the latest treatments, look up information on a drug or supplement, find out the meanings of words, or view medical videos or illustrations. You can also get links to the latest medical research on your topic or find out about clinical trials on a disease or condition.

Health professionals and consumers alike can depend on it for information that is authoritative and up-to-date. MedlinePlus has extensive information from the National Institutes of Health and other trusted sources on over 1000 diseases and conditions. There are directories, a medical encyclopedia and a medical dictionary, health information in Spanish, extensive information on prescription and nonprescription drugs, health information from the media, and links to thousands of clinical trials. MedlinePlus is updated daily and can be bookmarked at the URL: **https://medlineplus.gov/**. There is no advertising on this site, nor does MedlinePlus endorse any company or product.

Non-Emergency

In The Plan Area

For non-emergency medical conditions requiring prompt attention, call your PCM before seeking care. Most PCM offices have evening or extended hours. They will make every attempt to see you. If you call after office hours, your call will be directed to the after-hours service to provide you with information or authorize treatment at a specific medical facility. If you are unable to contact your PCM, you may seek care at the nearest Urgent Care center without a referral. Examples of conditions that might require after-hours care include:

- Ear infection, fever, some cuts and burns, and serious respiratory infections
- Sprains and strains
- Illnesses such as respiratory infections, chicken pox, measles
- Backaches, earaches, sore throat

Outside the Plan Area

If you become ill or injured and require urgent, but not emergency care while traveling, call your PCM office during regular office hours or after-hours service. For advice, you may contact the 24-hour nurse line at the number on the back of your Member ID card. You can access Urgent Care when necessary, without a PCM referral.

Emergency or Urgent Care out of the Country or at Sea

If you become ill or injured while in another country or at sea and require urgent care, go to the nearest medical facility to receive the necessary treatment. The hospital or facility may demand immediate payment; if they do, be sure to ask for treatment information, bills and receipts. Within seven (7) days of your return, submit itemized bills in English and receipts to the Customer Service Department along with an explanation of the services and the identification information from your Johns Hopkins USFHP card. Your request for reimbursement should include:

- Proof of member's payment (copy of paid receipt, cancelled check, credit card statement, etc.)
- Copy of itemized bill, invoice or receipt
- Description of services
- Description of diagnosis
- Dates of service
- Provider ID#, name, address, phone number and email address
- Billed amount for each service

Emergency Prescriptions

Prescriptions may be filled at any Walgreens pharmacy in the United States. For the location nearest you, please log onto **walgreens.com**.

Note: If you are unable to locate a participating pharmacy and need to fill a prescription due to an emergent situation, please refer to page 21 of this handbook for details regarding coverage for emergent, out of network pharmacy claims.

Benefits

Covered Benefits

Johns Hopkins USFHP provides a comprehensive range of preventive, diagnostic and treatment services as defined by the Department of Defense (DoD) and the TRICARE Prime benefit. A complete listing of covered benefits, non-covered benefits and coverage limitations may be found online at **tricare.mil** under ***Covered Services***, and ***See What's Covered***.

Although a specific benefit or service may be listed as covered, it will be provided and paid for only if, in the judgment of your Health Plan provider, it is medically necessary for the prevention, diagnosis, or treatment of an illness or condition.

Note: No oral statement of any personnel shall modify or otherwise affect these benefits, limitations and exclusions. Nor shall an oral statement of any personnel convey or void any coverage, increase or reduce any benefits under this Plan, or be used in the prosecution or defense of a claim under this Plan.

Covered Services:

- Office visits to your primary care manager (PCM)
- Prescription drugs
- Authorized office visits to Plan specialists when your PCM refers you
- Preventive health services: well-baby, well-child and well-adult care
- Covered outpatient surgical procedures and anesthesia upon referral from your PCM
- After-hours services at a Plan health center or designated facility when authorized
- Maternity (prenatal and postpartum) and newborn care. Note: A global authorization from your PCM is required.
- Routine eye exams
- Emergency room visits for a medical emergency or when authorized by the Plan

Please review the chart on page 11 of this handbook for a list of standard medical services that are covered by the Plan.

Point of Service (POS) Option

Self referred, non-emergency services provided by a non-participating provider without prior authorization will be considered for payment at the lesser of either 50% of the allowed amount or 50% of the billed charges. POS benefits are paid only after a $300.00 individual or $600.00 family deductible has been met. For example, if a non-participating provider charges $500 for an office visit and USFHP's allowable charge is $350, USFHP would pay $25 under the point of service option. You would be responsible for the deductible ($300), the 50% coinsurance ($25) and the difference between our allowable and the non-participating providers charges ($150) for a total out of pocket expense of $475. Any amounts accrued under the point of service option do not accrue to the catastrophic cap. To minimize out of pocket expenses, we strongly encourage all members to seek care within our extensive network of participating providers.

Catastrophic Loss Protection Benefit (Catastrophic Cap)

As Johns Hopkins USFHP members, your family has an annual catastrophic loss protection limit (or catastrophic cap) for health care costs. This means there is a limit to your out-of-pocket expenses.

The catastrophic cap per enrollment year for active-duty family members is $1,288 per family, and $4,509 for retirees, retiree family members and survivors, per family, when the sponsor entered uniformed services on or after 1/1/2018. The catastrophic cap per enrollment year for active duty family members is $1,000 per family, and $3000 for retirees, retiree family members and survivors when the sponsor entered uniformed services before 1/1/2018. The enrollment year is based on the 12-month calendar year. Out-of-pocket expenses that contribute toward your cap include, enrollment fees, co-payments and cost shares. Once your catastrophic cap has been met, you and your family members will not have to pay any more out-of-pocket expenses for the remainder of that calendar year.

Johns Hopkins USFHP encourages you to keep track of your out-of-pocket expenses. If you find a discrepancy in the amount the Plan has credited toward your cap, please send receipts with sponsor's name and membership identification number to:

Johns Hopkins USFHP
Premium Billing Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076
410-424-4835
toll-free: 888-717-8282
fax: 410-424-4770
usfhpcustomerservice@jhhp.org

Note: Dental charges under United Concordia's "Concordia Advantage Network" do not count toward the catastrophic cap.

2025 Plan Benefits Chart

	Cost for Active-Duty Family Members Group A* / Group B**	Cost for Retirees, Family Members, and Survivors Group A* / Group B**	Cost for members enrolled in Medicare Part B Group A* / Group B**
Outpatient Services (subject to medical review)			
Office visits (Primary Care)	$0	$25	$0
Specialty office visits	$0	$38	$0
Maternity care (prenatal, postnatal)	$0	$0	$0
Well-child care (birth to age 6)	$0	$0	$0
Routine physical examinations[1]	$0	$0	$0
X-ray and lab tests[2]	$0	$0	$0
Ambulatory surgery (same day)	$0	$77	$0
Physical, Speech and Occupational therapy (when medically necessary)	$0	$38	$0
Cardiac Rehabilitation[3]	$0	$38	$0
Inpatient Services (subject to medical review)			
Hospitalization (semiprivate room and board)	$0	$193 per admission	$0
Physician services	$0	$0	$0
General nursing services	$0	$0	$0
Diagnostic tests, including lab and X-ray	$0	$0	$0
Operating room, anesthesia, and supplies	$0	$0	$0
Medically necessary supplies and services	$0	$0	$0
Physical, Speech and Occupational therapy (when medically necessary)	$0	$0	$0
Mental Health Services (subject to medical review)			
Outpatient care individual	$0	$38 per visit	$0
Outpatient care group	$0	$38 per visit	$0
Partial hospitalization, mental health	$0	$38 per visit	$0
Inpatient hospital psychiatric care	$0	$193 per admission	$0
Substance Abuse Treatment (subject to medical review)			
Outpatient care individual	$0	$38 per visit	$0
Outpatient group/family therapy	$0	$38 per visit	$0
Inpatient services (up to 7 days for detoxification per year)	$0	$193 per admission	$0
Inpatient rehabilitation	$0	$38 per visit	$0
Other Services			
Ambulance ground services[4] (when medically necessary)	$0	$51	$0
Ambulance air services[4] (when medically necessary)	$0	$20	$0
Dental care (basic preventive care)	Reduced fees	Reduced fees	Reduced fees
Durable medical equipment	$0	20%	$0
Emergency room services[5] (including out of area)	$0	$77	$0
Urgent Care Center	$0	$38	$0
Routine eye examination (1 per Plan year)	$0	$0	$0
Radiation / chemotherapy office visits	$0	$38	$0
Prescription drugs co-pays[6] ***(Participating Retail)*** (up to a 30 day supply)	$16 generic, $43 brand $76 non-pref brand	$16 generic, $43 brand $76 non-pref brand	$16 generic, $43 brand $76 non-pref brand
Prescription drugs co-pays[6] ***(Home Delivery Available)*** (up to a 90 day supply)	$13 generic, $38 brand $76 non-pref brand	$13 generic, $38 brand $76 non-pref brand	$13 generic, $38 brand $76 non-pref brand
Skilled nursing facility care	$0	$38 per day	$0
Home health care (part-time skilled nursing care)	$0	$0	$0
Out of area (emergency services only)	$0	$77	$0
Catastrophic Cap			
(Maximum out-of-pocket expense per family)	$1,000* / $1,288** per plan year	$3,000* / $4,509** per plan year	$3,000* / 4,509** per plan year
Premium Fee[7]			
(Annual prices shown. Quarterly and Monthly are available)	$0	$372* / individual $744* / family $450** / individual $900.96** / family	$0 (with proof of Part B enrollment)

** For enlistment or appointment prior to January 1, 2018 /*
*** For enlistment or appointment on or after January 1, 2018*

Footnotes to Plan Benefits Chart

1. Routine Physical Examinations – while there is no co-pay for a Routine Physical; an office visit co-pay may be assessed if other procedures (not considered routine) are conducted during the examination.
2. If lab services are provided on the same day as the office visit and a co-pay is collected for the visit, no additional co-pay will be collected. No co-pay will be collected when services are billed and provided as clinical preventive services. Exceptions: Co-pay may be required for certain radiation oncology, vascular and pulmonary procedures and studies. Contact Customer Service for details.
3. Outpatient treatment following the initial intake evaluation and testing is limited to a maximum of 36 sessions per cardiac event.
4. Upon arrival of the ambulance and member refuses transport, the member is liable/responsible for services rendered.
5. Unless you are admitted to the hospital, in which case only the inpatient co-payment applies.
6. Prescription drug availability is limited to drugs prescribed by a Plan provider and covered as a Plan benefit. Availability of non-emergency prescriptions when out of the area is also limited.

Limitations to Benefits

The Plan does not provide coverage and will not pay for:

- Services not considered medically necessary or clinically appropriate for diagnosis and treatment as determined by a physician
- Services or procedures that are experimental or of a research nature, except for approved NCI trials
- Any services (including vaccinations) provided for employment, licensing, immigration, recreational travel, or other administrative reasons
- Cosmetic, plastic, or reconstructive surgery not related to medical treatment
- Most custodial or convalescent care (caring for someone's daily needs, such as eating, dressing and simple bandage changes) in an institution or at home
- Routine dental care and dental X-rays; treatment of teeth, gums, alveolar process or gingival issues; cranial mandibular disorders, and other issues related to the joint. (Call United Concordia at 866-357-3304 for information on discounts provided by Johns Hopkins USFHP)
- Services provided or charges incurred prior to the effective date of coverage under the Plan
- Services provided or received after the date your coverage is terminated under the Plan

Note: This list is not complete and other limitations may exist.

Examples of Specific Exclusions and Limitations

- Abortions (routine)
- Acupuncture and acupressure
- Artificial insemination, in vitro fertilization and other such therapies to induce pregnancy
- Autopsy and postmortem
- Aversion therapy (including electric shock and the use of chemicals for alcoholism, except for disulfiram, which is covered for the treatment of alcoholism)
- Chiropractic and naturopathic services
- Corrective lenses and frames
- Counseling services, unless medically necessary
- Cutting nails, trimming corns or calluses (except if diabetic or peripheral vascular disease)
- Education or training

- Food and vitamins consumed outside a hospital except for home parenteral nutrition therapy and certain medically necessary foods when prescribed and preauthorized for a covered diagnosis
- Learning disorders treatment
- Massage therapy
- Megavitamins and orthomolecular psychiatric therapy
- Orthodontia
- Orthopedic shoes and orthotics, except when part of a brace or in connection with medical treatment, e.g., diabetes treatment
- Private hospital rooms, unless ordered by the attending physician for medical reasons or if a semiprivate room is not available
- Radial keratotomy
- Retirement homes, Assisted Living, Long Term Care
- Some sexual dysfunction treatments
- Sterilization reversals
- Work-related illnesses or injuries that are covered under workers' compensation programs

Other exclusions may apply as defined by the TRICARE Prime benefit. Check with a customer service representative for further clarification.

Other Services

Ambulance Service

Benefits are provided for medically necessary, life-sustaining, ambulance-transport services furnished when use of any other method of transportation is inadvisable. If you are a retiree over age 65 or a retiree family member and you do not carry Medicare Part B, your co-payment is $51 per occurrence for ambulance services. Active-duty family members and retirees with current Medicare Part B do not have a co-payment for ambulance services.

Dental Care

Johns Hopkins USFHP, under a separate agreement has arranged for members to receive dental services from participating community dentists referred to as the Concordia Advantage Network.

Call Concordia Advantage Network at 800-332-0366 or visit Johns Hopkins USFHP Client's Corner page at ucci.com/jhusfhp for more information about specific dental benefits.

What's Covered

Two routine dental cleanings per year are covered. (Billing codes associated with the routine cleanings are D1110 for adults, defined as those members who are age 13 and up, and D1120 for children up to age 13.)

How to Obtain Your Free Cleaning

Call or go to the UCCI Client's Corner page for the list of Concordia Advantage Network providers in your area.

- Select a provider. Call for an appointment.
- Confirm that the provider participates in the Concordia Advantage Network.
- At the time of the appointment, show your Johns Hopkins USFHP membership card when you check in.
- Your dentist will bill United Concordia directly for the cost of the cleaning. You will have no out-of-pocket expense for the cleaning.

Coverage Limitations

Other services that may be associated with the cleaning, such as X-rays, fillings, etc., are not covered by Johns Hopkins USFHP. However, discounts for these other services may exist as applicable by law. If you receive other services listed on the Concordia Advantage Network Member Fee Schedule, you will be expected to pay the dentist directly at the reduced rate. If you receive a service that is not listed on the fee schedule or you receive dental care outside of the service area, you will be responsible for the dentist's normal charges for that visit.

Vision Care

Covered Benefit

One routine eye examination per year, including refractions and written lens prescription, may be obtained from designated Plan providers. You may obtain eye care at any Johns Hopkins Wilmer Eye Institute, Superior Vision provider location, or contracted community provider. Call Superior Vision at 800-428-8789 or visit **https://superiorvision.com** to find the nearest locations.

- Diagnosis and treatment of eye disease is covered in the same manner as any other medical specialty and requires a referral from your primary care manager (PCM).

Non-Covered Benefit

- Corrective vision lenses, frames, corrective vision contact lenses and contact lens fittings are not covered.
- Corrective vision surgery is not covered (e.g., LASIK*, radial keratotomy, PRK, etc)

*A discount on laser vision correction services is available to members. For more information, visit **hopkinsusfhp.org/dental-vision-and-discounted-services**.

Note: Under a separate agreement, Johns Hopkins USFHP has arranged for Plan members to receive discounted prices for corrective lenses and frames at all Wilmer Optical Shops and Superior Vision locations.

Diagnostic Services

If requested by your primary care manager or specialist, the following may be covered without an additional co-payment when performed by a participating provider:

- Pathology/lab services
- Nuclear medicine services
- Cardiovascular studies
- Radiology/ultrasound services

However, if you have a PCM or specialist office visit on the same day as the diagnostic services, a co-pay will be collected from retirees and their family members who do not carry Medicare Part B for the PCM/specialist visit. Active-duty family members and retirees with current Medicare Part B are not required to pay co-pays for most services.

Hospice Care

Hospice care provides an integrated set of services and supplies for the care of the terminally ill. This type of care emphasizes palliative care and symptom management through supportive services, such as some limited multidisciplinary home care, inpatient symptom management and periodic, brief, inpatient respite-care stays. The benefit provides coverage for a humane and sensible approach to care during the end of life for terminally ill patients.

Note: Eligibility determinations and referrals to approved hospice care providers are made by primary care managers or specialists using established medical criteria.

Behavioral Health

What Is Covered

The Plan provides medically and psychologically necessary services for the diagnosis and treatment of substance abuse and mental health conditions provided by licensed professionals including psychiatrists, psychologists, clinical social workers, and, certified marriage and family therapists.

Covered services include:

- Diagnostic evaluation
- Behavioral therapy (positive reinforcement methods only)
- Psychological testing subject to medical review
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services), subject to behavioral health review

For office based mental health services Johns Hopkins USFHP members may self-refer to an in-network participating mental health provider. For behavioral health care provider locator and appointment assistance, please call 888-309-4573.

Treatment for chemical and alcohol dependency at approved in-network inpatient treatment facilities is covered when preauthorized by the Plan.

If a new Plan member is currently under treatment for a mental health condition or chemical or alcohol dependency from a non-Plan provider, please call 410-424-4830 or 888-281-3186 to transfer your care to a Plan provider. The Plan covers only approved services from an in-network participating provider.

What Is Not Covered

Every effort is made to assist members to obtain the necessary services at the right level of care. There are some exclusions to the Plan. The following are examples of excluded services:*

- Treatment of disorders of sexual functioning
- Support services and groups that are not time-limited or not conducted by a licensed professional
- Learning disabilities including psychological testing for academic and intelligence testing

* Other limitations may exist.

National Cancer Institute Clinical Trials

Through its contract with the DoD the Plan has access to the National Cancer Institute (NCI) to treat patients who suffer from cancer. Plan members who meet specific criteria will have access to promising new cancer therapies in test stages. If accepted to a clinical trial, patients will have access to treatment. The DoD finances some of the sponsored studies including Phase II and Phase III protocols approved by the NCI for all types of cancer. Phase I cancer trials will be covered for USFHP on a case by case basis. Medical review and approval will be done to validate criteria for coverage has been met. More information is available about this program at cancer.gov. If you are interested in participating in the program, please contact the Plan's Care Management Department at 800-556-0196.

Durable Medical Equipment

Durable medical equipment may be covered if deemed medically necessary and prescribed by your primary care manager and purchased or rented from a Plan provider. A 20% co-insurance is applied for retirees and their family members who do not carry Medicare Part B. Active-duty family members and retirees with current Medicare Part B are not responsible for the co-payment.

ECHO (Extended Care Health Option)

ECHO provides financial assistance only for active-duty family members with specific qualifying mental or physical conditions. Some conditions include (please note this is not an all-inclusive list):

- Diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler expected to precede a diagnosis of moderate or severe mental retardation or serious physical disability
- Extraordinary physical or psychological condition causing the beneficiary to be homebound
- Moderate or severe mental retardation
- Multiple disabilities (may qualify if there are two or more disabilities affecting separate body systems)
- Serious physical disability

ECHO Benefits

ECHO benefits, services and supplies are not available through the basic Johns Hopkins USFHP. ECHO benefits provide such coverage as:

- Assistive services (e.g., those from a qualified interpreter or translator)
- Durable equipment, including adaptation and maintenance
- Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC)
- Medical and rehabilitative services
- In-home respite care services
  - EHHC respite care—up to eight hours per day, five days per week for those who qualify
    Note: The EHHC benefit cap is equivalent to what TRICARE would reimburse if the beneficiary was in a skilled nursing facility
- Training to use assistive technology devices
- Institutional care when a residential environment is required
- Special education
- Transportation under certain limited circumstances (includes the cost of a medical attendant when needed to safely transport the beneficiary)

All ECHO services require preauthorization through Johns Hopkins USFHP Utilization Management.

ECHO Eligibility Process

For general questions, potential ECHO enrollees or family members may call the USFHP customer service telephone number at 410-424-4528 or 800-808-7347. USFHP also has a dedicated ECHO team. A member of the ECHO team will assist members by answering more detailed questions regarding the eligibility and enrollment process.

To enroll in the ECHO program, members must be currently enrolled in Johns Hopkins USFHP, enrolled in the Exceptional Family Member Program (EFMP) of their branch of service and provide medical documentation that a qualifying condition exists. USFHP will grant provisional ECHO enrollment (for 90 days) while the sponsor completes the EFMP forms. Upon receipt of the application and documentation, members will receive a decision letter with their eligibility status.

ECHO Costs

Active-duty sponsors pay a cost-share that is based on their pay grade and is separate from other USFHP program cost-shares. The monthly cost-share is one fee per sponsor, not per ECHO beneficiary.

Sponsor's Pay Grade	Monthly Cost-Share
E-1 to E-5	$25
E-6	$30
E-7, O-1	$35
E-8, O-2	$40
E-9, WO/WO-1, CWO-2, O-3	$45
CWO-3, CWO-4, O-4	$50
CWO-5, O-5	$65
O-6	$75
O-7	$100
O-8	$150
O-9	$200
O-10	$250

The maximum government cost-share is $36,000 per beneficiary, per calendar year (CY) (January 1st - December 31st). Sponsors are responsible for the cost of ECHO benefits that exceed this limit.

Note: The ECHO Home Health Care (EHHC) benefit is not subject to the $36,000 per CY maximum government cost-share. The sponsor's cost-share does not count toward the annual catastrophic cap. ECHO costs cannot be shared between family members. For more information about ECHO, you can also visit tricare.mil (see benefit information) or go to **hopkinsusfhp.org/plan/benefits-costs/discounts/**.

Evaluation of New Technology, Drugs and Benefits

A TRICARE benefit must meet three basic requirements:

- It cannot be excluded by law (statute) or regulation (Code of Federal Regulations)
- It must be medically necessary and appropriate (proven, safe and effective) and represent the standard for good health care in the United States
- It must be funded and administratively added to the TRICARE program

New benefits or revisions of existing benefits are made by the DoD *Defense Health Agency* (DHA) after extended research, review, and collaboration. The need for benefit changes are identified by:

- Reviewing changes to federal law
- Monitoring changes in national health care coverage and reimbursement
- Requests for scientific review from within and outside DHA
- Researching and reviewing appeals of denied services under the current benefit program

Care Management

At no cost to you, the USFHP Care Management program offers you the tools and ongoing support you need to better understand and manage your health.

USFHP's Care Management services give you individual support and services that are designed to help you understand and self-manage your medical conditions.

It can be overwhelming to manage all of your health needs. If you need help with this, ask for a care manager. Care managers are registered nurses and licensed clinical social workers who can teach you more about your conditions and how to manage them. They work with all of the providers in your care team. They advocate for you to help you achieve your best health.

No matter where you are on your health journey, we have services to support you. Your USFHP care team is ready to help you do more for your health.

You, your care manager, and your health care providers can collaborate to improve your health by:

- Determining your personal needs and wellness
- Building your skills to help you better manage your conditions
- Helping with referrals to specialists
- Managing the supplies and services you need for your health care

Work with a care manager if you:

- Are pregnant
- Have a chronic health condition like diabetes, hypertension, or COPD
- Are ending a hospital stay
- Want help with advance care planning

Preventive Health

Johns Hopkins USFHP wants to help you to avoid complications and stay healthy. The Plan will remind you of services you need and give you information that you can trust.

Care Managers are registered nurses and licensed clinical social workers. These advocates work with you and coordinate care with your providers, offering support, guidance and encouragement to help you achieve your best health.

Transition of Care

Care Managers can provide you with assistance navigating the health care system following a health event such as an emergency room (ER) visit, hospitalization, new diagnosis or significant life event. Care Managers can help you get the appropriate provider follow-up after an ER visit, hospitalization or significant life event, as well as access to the medications or other medical supplies you need to continue your treatment. Care Manager support as you transition from one treatment setting can help you better manage your health and reduce the need to go to the hospital.

Complex Care

Johns Hopkins USFHP can guide you to partner with a registered nurse or licensed social worker care manager to help reach your best level of health. Learn more about a new diagnosis or improve your knowledge and skills in managing a chronic health condition. We work with you and your providers to help you understand and take better care of your complex health conditions. We help coordinate your care and work one-on-one to make it easier for you to focus on your health.

Behavioral Health

Your mental health is vital. Receive confidential support from a licensed clinical social worker if you have a mental health or substance abuse concern. 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**.

Maternal/ Child Health

Johns Hopkins maternal/ child care managers can also help you if you are pregnant, postpartum or a parent/ caregiver of newborns and children. Registered nurse care managers can provide you with care coordination, health education and help connect you to services and resources for you and your family. If your baby needs care in the NICU, maternal/ child health care managers work with you to help you understand your baby's care needs, assist you in the transition home.

If you're ready to talk, your care team is ready to help.

How to Self-Refer

Johns Hopkins USFHP encourages you to take advantage of the services and programs provided by Care Management. Care Management services are voluntary and are provided at no cost to members. Members identified with certain needs may be automatically enrolled, but there is no obligation to participate in these programs.

You can opt out of the services at any time by contacting Care Management.

If you have questions about our Care Management services, or if you would like to refer yourself or a loved one to a program, call toll-free at 800-557-6916. This number may also be used to opt-out of Care Management services. We are available Monday through Friday, 8:30 a.m. to 5:00 p.m. Any voicemail messages received after normal business hours will be addressed the next business day. We can also be contacted by e-mail at **CareManagement@jhhp.org.** For more information about how to use Care Management services, go to **hopkinsusfhp.org/health-and-wellness/care-management/**.

Health Education

You may also receive assistance from our Health Educators who advocate, encourage and teach you about healthy lifestyles and living well with a chronic condition. Our Health Educators offer health education classes and activities, and collaborate with our care managers to provide important health education to support your treatment needs. You may attend one of our many interactive programs to give you information, tips and tools to better manage your health.

There is always something new to learn about staying healthy. Johns Hopkins USFHP offers a wide variety of interactive health education programs and workshops to teach you how to take better care of yourself. Best of all, these programs offer a supportive group environment where members can encourage each other and learn from one another's experiences.

Topics include:

- Baby Basics
- Diabetes
- Pre-diabetes
- COPD (Chronic Obstructive Pulmonary Disease)
- Asthma
- Blood Pressure
- Heart Disease
- Nutrition
- Weight Management
- Physical Activity
- Quitting Smoking
- Sleep
- Anxiety and Stress Management

For more information regarding virtual health education classes, go to **hopkinsusfhp.org/health-and-wellness/health-education/** or call 800-957-9760 or email healtheducation@jhhp.org

Utilization Management

USFHP's Utilization Management (UM) evaluates requests for services that require prior authorization. Services that may require a prior authorization from UM before services are provided may include: specialty medical care, inpatient mental health treatment and inpatient substance-abuse treatment. The "If You Need Specialty Care" section of this handbook describes how to obtain a referral for specialty care.

The goals of the UM program are to:

- Provide a system of pre, post and urgent requests for authorizations that are evaluated to determine the necessity and/or appropriateness of services being authorized;
- ensure continuity and consistency of benefit and clinical criteria administration.

UM decision-making is based only on appropriateness of care and service, and existence of coverage. No person may participate in the review of any case which he/she has professional or personal involvement or where judgment may be compromised. There are no rewards to practitioners, providers or UM staff to encourage barriers to care and service through the issuance of denials of coverage or requested services. There are no financial incentives for UM decision makers to encourage decisions that result in underutilization of services.

Often this requires prior authorization by the health plan and is required for certain services and/or elective hospital admissions. UM decision making is based on appropriateness of care and service, and existence of coverage. Licensed medical professionals administer the UM policies and procedures and may approve services, and the Plan Medical Director reviews and renders all UM denials involving medical necessity, cosmetic and/or investigational decision-making. For additional information on services requiring authorization, refer to the USFHP website **hopkinsusfhp.org/plan-documents**.

To contact UM, call 410-424-4480 or 800-261-242 (TDD/TTY 711 or 800-201-7165) weekdays from 8 a.m. to 5 p.m. After normal business hours, please leave a phone message and your call will be returned on the next business day. Language interpreter assistance is available and can be requested by contacting Customer Service at 410-424-4528 or 800-808-7347.

Pharmacy and Prescription Drug Services

Retail Pharmacy Network

You may obtain your prescriptions at any of the approximately 8,100 Walgreens network pharmacies nationwide. You may fill prescriptions for up to a 90-day supply of medications. To fill a prescription, present your Johns Hopkins USFHP Member ID Card to the pharmacist with your prescription. You will be required to pay a co-payment (co-pay) at the time of service. Your ID card contains important information to allow the pharmacy to process your claim correctly. For the location of a Walgreens pharmacy near you, visit **walgreens.com**.

Note: You may not obtain prescriptions from a Military Treatment Facility and government/federal military pharmacies, including Veterans Affairs (VA) pharmacies while enrolled in USFHP. Prescriptions that originated at a military treatment facility may not be transferable to Walgreens pharmacies.

Any prescriptions filled outside of Walgreens' network in a non-emergent situation will be reviewed for medical necessity and if approved, will be reimbursed at the USFHP contracted rate less applicable co-payment. This includes prescriptions filled from a non Walgreens Pharmacy during inpatient stays at nursing or assisted living facilities. See the section titled "Out of Network Claims."

Home Delivery/Mail Order Pharmacy

Home delivery is available to USFHP members for up to a 90-day supply of approved medications through Walgreens. Home delivery is best suited for medications you take on a regular basis.

If you live in Maryland, you may obtain your prescription through home delivery by completing the Pharmacy Home Delivery (Maryland residents) form, available at **hopkinsusfhp.org/members/plan-documents**. Once completed, send it in with your new prescription, plus a check or credit card number for your copayment, to the address listed on the form. To ensure you receive a refill before your current supply runs out, reorder at least two weeks before you need your refill.

If you live outside of Maryland, you may obtain your prescription through home delivery from AllianceRx

Walgreens Prime pharmacy. For more information, visit the AllianceRX Walgreens Prime website at **alliancerxwp.com/home-delivery**.

To obtain home delivery, fill out the Out of State Pharmacy Home Delivery form, available at **hopkinsusfhp.org/members/plan-documents**, and mail to the address listed on the form.

To request refills, you may submit the form electronically by logging into your HealthLink@Hopkins account. Attach the completed form to a new message in your Message Center and then send the message to Customer Service. Your request will be forwarded to the Walgreens Pharmacy for fulfillment.
Your prescription order is processed promptly and most orders are received within two weeks. To ensure you receive a refill before your current supply runs out, re-order at least two weeks before you need your refill. Failure to include appropriate co-payment amount may delay delivery of your medication.

Vaccine Administration at Walgreens Pharmacies

The Centers for Disease Control (CDC) recommends that everyone 6 months of age and older receive the flu vaccine. Vaccination is especially important for health care workers, young children, pregnant women, people with chronic health conditions and people age 65 years and older.

Influenza is a contagious disease spread by coughing, sneezing, and nasal secretions. Vaccination is the best protection against getting the flu! Get your free flu vaccine at your Walgreens pharmacy and protect yourself from flu symptoms all season long.
USFHP members (9 years of age and older) can receive a free flu vaccine at participating Walgreens vaccine network pharmacies. This convenient option lets you get a vaccine even if you can't make it to your physician's office. And best of all, there is no cost to you.

Travel Vaccines*:

Certain vaccines are covered when required by dependents of active duty military personnel who are traveling outside of the U.S. as a result of an active duty member's duty assignment. Travel orders and a physician's prescription must accompany immunization voucher requests. Age restrictions apply. Email requests to Travel_Orders@jhhp.org.

* Recreational travel is not covered.

Other Vaccines:

You can get some covered vaccines at $0 from participating Walgreens pharmacy.

COVID-19: Adult and pediatric COVID-19 vaccines that are authorized or approved by the Food and Drug Administration are covered at $0 for members. Johns Hopkins USFHP and Johns Hopkins Medicine encourage all individuals to receive the vaccine and all families to consider having eligible children get the appropriate COVID-19 vaccine. Members can receive the vaccine from any Walgreens pharmacy.
You may find a participating Walgreens vaccine network pharmacy at **walgreens.com**.

Formulary and Co-Payments

Johns Hopkins USFHP utilizes the TRICARE pharmacy formulary. The TRICARE pharmacy formulary is a list of generic and brand prescription drugs that are covered under the TRICARE benefit. The TRICARE Formulary Search Tool can be found at

express-scripts.com/frontend/open-enrollment/tricare/fst/#/. USFHP members are responsible for a portion of the cost of their medications. The TRICARE formulary contains three cost levels for USFHP members. The cost shares are as follows:

Walgreens Retail (up to a 30 day supply)

Generic: $16 / Brand Name: $43 / Non-Formulary: $76

Walgreens Retail and Home Delivery

(up to a 90 day supply for maintenance medications)

Generic: $13 / Brand Name: $38 / Non-Formulary: $76

You can view the cost share for a medication using the TRICARE Formulary Search tool found on our Web site under **Members & Visitors, Pharmacies & Medications**, **Formulary**. You can also use the search tool to find lower cost alternative medications to a medication you are currently taking.

Covered Medications

The Johns Hopkins USFHP Pharmacy Program covers medications that are approved by the U.S. Food and Drug Administration (FDA) and that generally require a prescription. Other covered medications include:

- Insulin
- Insulin syringes and needles
- Smoking Cessation products at no out of pocket cost (Max of 2 quit attempts per yr.)
- Glucose test strips*
- Lancets
- Prenatal Multivitamins with a prescription

* Freestyle Lite & Precision Xtra strips are TRICARE preferred test strips. All other test strips will require prior authorization.

* Continuous glucose monitors (CGMs): FreeStyle Libre® Kit 2 sensor & reader, FreeStyle Libre® kit 3 sensor & reader, Dexcom G6® sensor, receiver & transmitter, and Dexcom G7® sensor & receiver (These CGMs require prior authorization at your local pharmacy and through home delivery)

All regular glucose monitors and continuous glucose monitors, such as Free Style Libre and Dexcom, are covered by your USFHP medical benefit. Use the Durable Medical Equipment (DME) directory, available at **hopkinsusfhp.org/members/plan-documents**, to find a supplier.

Non-Covered Medications

Prescription medications used to treat conditions that are not currently covered by USFHP, either by statute or regulation, are likewise excluded from the pharmacy benefit. Excluded medications include but are not limited to:

- Drugs prescribed for cosmetic purposes
- Fluoride preparations
- Food supplements, formulas and medical foods
- Homeopathic and herbal preparations
- Smoking cessation products covered under the smoking cessation benefit
- Any drugs otherwise excluded by the TRICARE Pharmacy Formulary

Formulary

Johns Hopkins USFHP utilizes the TRICARE Pharmacy Formulary. The TRICARE formulary and pharmaceutical management policies are developed by the Department of Defense Pharmacy and Therapeutics Committee. The TRICARE formulary is a tiered, open formulary and includes generic drugs (Tier 1), preferred brand drugs (Tier 2), and non-preferred brand drugs (Tier 3). Additional information about the DoD Pharmacy and Therapeutics review and list of formulary drugs can be found at **health.mil/formulary**.

Generic Drug Policy

Generic drugs are chemically identical to their branded 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. Generic drugs usually cost less than brand name drugs; you can save money on your co-payment by choosing generic drugs when applicable. Additional information on generic drugs is available on the FDA web site at: **fda.gov/Drugs/default.htm**.

DoD's policy on generic drugs requires the pharmacy to substitute generic medications for brand-name medications when a generic equivalent is available. Brand-name drugs with a generic equivalent may be dispensed only if your physician submits a medical necessity request and approval is granted by USFHP.

In those cases you will pay the brand-name co-payment.

If you insist on having a prescription filled with a brand name drug when a generic equivalent is available, and medical necessity for the brand name drug has not been established, you will be responsible for the entire cost of the prescription. Use the **Pharmacy Prior Authorization** form for establishing medical necessity for applicable drugs, found at **hopkinsusfhp.org/members/plan-documents/**. To determine a drug's eligibility for medical necessity visit the TRICARE Formulary website at: **express-scripts.com/frontend/open-enrollment/tricare/fst/#/.**

Quantity Limits

The Department of Defense Pharmacy and Therapeutics Committee has established quantity limits for certain medications. If your medical condition warrants use of quantities greater than the listed quantity limit for your medication, your provider may submit a Prior Authorization request for use of the higher quantity. Your physician must provide medical justification for use of the higher quantity. To determine if there is a quantity limit on a medication you take, use the TRICARE Formulary Search tool and view drug specific information: **express-scripts.com/frontend/open-enrollment/tricare/fst/#/**.

To initiate a quantity limit prior-authorization your provider must complete and fax the Prior Authorization form to the Johns Hopkins Health Plans Pharmacy Review department at 410-424-4607.
To download a copy of the Pharmacy Prior-Authorization form, visit here: **hopkinsusfhp.org/members/plan-documents/.**

Prior Authorization

Some medications require prior authorization before they can be dispensed.

To determine if a medication requires a prior authorization, use the TRICARE Pharmacy Formulary Search Tool at: **express-scripts.com/frontend/open-enrollment/tricare/fst/#/**

To initiate a prior authorization your provider must complete and fax the Prior Authorization form to the Johns Hopkins Health Plans Pharmacy Review department at 410-424-4607.

To download a copy of the Pharmacy Prior-Authorization form, visit here: **hopkinsusfhp.org/members/plan-documents/.**

Step Therapy

Step therapy involves prescribing a safe, clinically effective, and cost-effective medication as the first step in treating a medical condition. The preferred medication is often a generic medication that offers the best overall value in terms of safety, effectiveness and cost. Non-formulary drugs are only prescribed if the preferred medication is ineffective or poorly tolerated.

Drugs subject to step therapy will be approved for first-time users only after they have tried one of the preferred agents on the TRICARE Formulary.

Note: If you filled a prescription for a step therapy drug within 180 days prior to the implementation of step therapy, you will not be affected by step therapy requirements and will not be required to switch medications.

Medical Necessity for Non-Formulary Medications (at Formulary Co-payments)

Medical necessity criteria are established by the DoD Pharmacy & Therapeutics (P&T) Committee for each non-formulary medication. If the medical necessity criteria are met, the beneficiary may receive the non-formulary medication at a lower co-payment where applicable. Your provider can establish medical necessity by completing and submitting the Pharmacy Prior Authorization form.

To download a copy of the Pharmacy Prior-Authorization form, visit here: **hopkinsusfhp.org/members/plan-documents/.**

Out of Network Claims/ Reimbursement

In the event that you fill a prescription at an out of network pharmacy due to an emergent situation, you may seek reimbursement for the incurred cost. To obtain reimbursement, complete the Prescription Reimbursement Claim form and mail to the address indicated on the form. You will be reimbursed for the cost of the prescription less applicable co-payment. Any prescriptions filled outside the Walgreens network in a non-emergent situation will be reviewed for medical necessity and if approved, will be reimbursed at the USFHP contracted rate less applicable co-payment. This includes prescriptions filled from a non-Walgreens Pharmacy during inpatient stays at nursing or assisted living facilities.

To download a copy of the Prescription Reimbursement Claim Form, visit here: **hopkinsusfhp.org/members/plan-documents/.**

Online Coordination of Benefits

USFHP beneficiaries who have other health insurance (OHI) can take advantage of online coordination of benefits (COB). Tell your pharmacist you have Johns Hopkins USFHP coverage in addition to your OHI when you have your prescription filled at your retail network pharmacy. Your pharmacist will submit your prescription online to both plans at the same time. The online COB process is only applicable at Walgreens pharmacies. If your primary insurance requires use of a pharmacy other than Walgreens, you may seek reimbursement for the eligible portion of your out of pocket expense. To obtain reimbursement, complete the Prescription Drug Claim form at **hopkinsusfhp.org/members/plan-documents/** and mail to the address indicated on the form.

Advantages of having your COB claims processed online include:

- Zero out-of-pocket expense
- No need to submit paper claims
- Reduced or eliminated up-front costs

Johns Hopkins USFHP becomes the first payer when:

- The drug is not covered by your OHI, but is covered by TRICARE
- Coverage under your OHI is exhausted for the benefit year

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 by your pharmacy benefit are available at a local pharmacy. You take these medications on your own. For some of them, your provider may have to ask Johns Hopkins USFHP to approve them. Search the TRICARE Formulary for the specialty medications covered under the pharmacy benefit.

Some medications may not be available at local network pharmacies because of the medication's manufacturer limits. If your physician submits a request for use of a limited or restricted distribution drug, upon approval Johns Hopkins USFHP will forward the request to a contracted specialty pharmacy. The specialty pharmacy will coordinate delivery of the medication to the patient's home or physician office.

Specialty medications covered under your 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 provider may have to ask Johns Hopkins USFHP to approve them.

Your doctor may find a list of medical drugs that have this prior authorization requirement and more information about how to submit a prior authorization request by visiting **hopkinsusfhp.org/members/my-benefits/pharmacy**.

Drug Information

To view information on a drug, generic availability, how to take the medication, possible side effects, risks and drug interactions visit **walgreens.com**

Prescription Drug Recalls

Johns Hopkins USFHP cares about your safety.

When Walgreens is notified by the Food and Drug Administration (FDA) about a Class I, Class II or voluntary drug recall, on behalf of USFHP, they promptly notify affected members and their prescribing doctors by mail.

For Class I recalls, situations where there is reasonable probability of a serious adverse health consequences caused by a medication, members and prescribers will be notified within 7 calendar days of health plan notification by the FDA.

For Class II recalls, where a medication may cause temporary or medically reversible adverse health consequences, or in the case of a drug withdrawal from the market by a manufacturer, members and prescribers are notified within 30 calendar days of health plan notification by the FDA.

Members who receive recall notices are urged to contact their prescriber for further instructions. More information regarding drug recalls, market withdrawals and safety information can be found at **fda.gov**.

Skilled Nursing Care

Inpatient Skilled Nursing Care

The Plan provides inpatient skilled nursing care in an accredited, contracted skilled nursing facility when it is medically necessary. Coverage includes:

- Bed, board and skilled nursing services in a subacute or rehabilitation facility
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the facility when authorized by a Plan provider
- Other medically necessary treatments and services deemed appropriate

Note: Short- or long-term custodial care is not covered.

Home Care

The Plan provides medically necessary home care for beneficiaries who are homebound or whose condition is such that home visits are indicated, including:

- Durable medical equipment such as wheelchairs, hospital beds, oxygen, and respirators when arranged by the Plan
- Home physical therapy, speech therapy, or occupational therapy for short, defined periods when significant improvement can be expected

Note: Home care is covered only when such care is medically necessary and authorized by the Plan and is limited to skilled services. Assistance with the ordinary activities of daily living such as eating, dressing, etc., is not covered.

Enrollment in the Plan

Enrollment in USFHP is automatically renewed, unless your eligibility or standing changes. Beneficiaries may choose to enroll, change, or terminate coverage during Open Season, which begins the Monday of the second full week in November and ends the Monday of the second full week in December of each calendar year. Once enrolled, members may not disenroll until Open Season, unless they experience a qualifying life event (QLE) or they fail to pay applicable premium fees. Upon disenrollment, a beneficiary can continue to see his or her primary care manager under TRICARE Select or Medicare/TRICARE For Life as long as the beneficiary is still eligible through the Defense Enrollment Eligibility Reporting System (DEERS). Enrollment changes can be made within 90 days of a QLE. If no enrollment changes are made, coverage will continue from year-to-year unless otherwise terminated.

Eligibility

To maintain your enrollment in the Plan, you must be registered with DEERS as eligible to receive health care benefits and have a valid Military ID. To maintain your coverage, keep your DEERS record up to date. If you have any questions about your DEERS eligibility, call 800-538-9552 or go to **https://www.tricare.mil/DEERS**

Beneficiary Web Enrollment (BWE)

You can make changes to your DEERS account as well as enroll in Johns Hopkins USFHP using TRICARE'S Beneficiary Web Enrollment (BWE) portal. You can

access the portal by logging onto **hopkinsusfhp.org** and going to the Enroll Now section.

To log on you must have one of the following:

- Valid CAC (Certified Common Access Card)
- DFAS (Defense Financial and Accounting Services) myPay login ID and password
- Department of Defense Self-Service Logon

Some of the features include:

- Enroll or Transfer enrollment to a new region
- Update personal contact information such as address, phone number and email in DEERS and USFHP
- Make initial credit card payment
- Convert enrollment from active duty to retiree status up to 60 days before retirement (DEERS must reflect retirement status)
- Add information about other health insurance to your DEERS record
- View enrollment information

Military Treatment Facility Privileges

As a condition of membership, Plan members are not permitted to use a military treatment facility (MTF) for non-emergency care, including the MTF pharmacy. MTF pharmacies are not included in the USFHP network and cannot be used. However, should you experience a life- or limb-threatening emergency, you are permitted to use the nearest civilian or military emergency facility. You must notify your primary care manager within 24 hours of receiving care. Claims for emergency treatment should be submitted to the Plan for payment.

Changes Affecting Eligibility

Adding a Family Member (except a newborn or adopted child)

Your family member is not automatically covered by TRICARE Prime. To make sure your family member is enrolled in TRICARE Prime, you must complete two steps.

- Update your family member's eligibility in DEERS by visiting a RAPIDS site and
- Submit a TRICARE Prime Enrollment Application and Primary Care Manager Change form (DD Form 2876), or you may enroll online via the Beneficiary Web Enrollment Web site at **dmdc.osd.mil/appj/bwe/** or telephone your request.

Having a Baby or Adopting a Child

TRICARE -eligible newborns are considered TRICARE Prime as of the date of birth if the uniform services member sponsor is showing as eligible in DEERS (enrolled or non enrolled), or the non-active duty sponsor or another family is enrolled in Prime.

Please notify the Enrollment Department as soon as possible after the birth or adoption of the child in order to expedite payment of all delivery charges. In addition, the newborn or adoptee needs to be enrolled in DEERS within 90 days from the date of birth or adoption.

Failure to register your child into DEERS within 90 days will result in termination of your child's membership in Johns Hopkins USFHP on the 91st day after his/her birth or adoption. The effective date of coverage for a newborn whose mother is not a member of the USFHP is the date we receive the application for enrollment of the infant. Also, the newborn must be enrolled in Johns Hopkins USFHP at the time the application is received.

Change of Address

Please let us know if your mailing address within our service area changes for any reason by contacting the USFHP.

Active Duty to Retired

A TRICARE Prime enrollment request (enrollment form, BWE Transaction, or telephonic) must be received within 30 days of the sponsor's retirement to qualify for continuous coverage. Family members must have been enrolled with TRICARE Prime on the sponsor's last day of active duty orders to qualify for continuous coverage.

TRICARE Select and TRICARE for Life

By enrolling in the Plan, you have agreed to receive your health care through Johns Hopkins USFHP. DoD has required as a condition of membership that you agree not to use TRICARE Select, or TRICARE for Life while a member of the USFHP.

Membership and Medicare

Oct. 1, 2012 and later	Prior to Oct. 1, 2012
Tricare for Life	Continued eligibility in Johns Hopkins USFHP

You may contact Customer Service to verify your membership effective date.

If you are Medicare-eligible and enrolled in Johns Hopkins USFHP, your Medicare coverage remains in effect. However, as a condition of membership, you have agreed not to use Medicare Parts A and B or to enroll in a Medicare-sponsored managed care plan (HMO) such as Medicare Advantage plans while enrolled with Johns Hopkins USFHP. You are expected to receive all health care services through Johns Hopkins USFHP. Using Medicare benefits while a Plan member may result in disenrollment. However, you may use Medicare for certain benefits that are not covered by the Plan.

Contact Customer Service prior to using Medicare for non-covered benefits to ensure that such use does not compromise your membership in Johns Hopkins USFHP.

Medicare Part B

When you become Medicare-eligible, you are advised to enroll in Medicare Part B to avoid penalties or waiting periods should you choose to leave the Plan and need to use your Medicare benefits.
Note: Retirees with current Medicare Part B are not required to pay annual enrollment fees and co-pays (except for pharmacy). This applies to Group A only.

If You Are About to Become Eligible for Medicare Benefits

See above for eligibility.

Medicare and Johns Hopkins USFHP

It is important to remember:

- Once you have received your Medicare Part B card in the mail, make sure to update your Medicare status with DEERS in person, online or by phone. Your new JH USFHP member ID card with a $0 copay change will be mailed to you automatically after updating DEERS. Present this ID card ONLY when visiting your provider.
- Medicare must not be billed for services covered by the Plan.
- Members filing Medicare claims or who have claims filed on their behalf are in violation of the conditions of participation for the Plan and may be disenrolled.
- Members who have coverage under both the Plan and Medicare may only use Medicare benefits for services not covered by the Plan such as chiropractic care or end-stage renal disease (ESRD).
- For all medical services, Medicare will be billed (as primary) for members with ESRD.

Enrollment Fees

Eligible retirees, their family members, survivors and eligible former spouses who do not participate in Medicare Part B are required to pay an enrollment fee. The enrollment fee is payable at the time of enrollment into the Plan. Once enrolled, enrollment fees must be paid by an allotment from a retirement account. Payments by credit card are only permitted with an approved exemption from the DHA allotment requirement. Allotment waivers will be granted for the following situations: 100% disability, surviving dependents, utilizing VA benefits, no retirement account or not enough funds in a retirement account to cover enrollment fees. To request an exemption from the allotment requirement and to complete a waiver form, visit **hopkinsusfhp.org/pay-my-premium** or call the Enrollment department.

Enrollees must pay the first quarterly installment (i.e., the first three months) at the time the enrollment application is submitted to allow time for the allotment to be established. We shall accept payment of the first quarterly installment by personal check, cashier's check or money order.

2025 Enrollment Fees:

Individual Enrollment:	Family Enrollment:
Group A $372 annually $31 monthly	Group A $744 annually $62 monthly
Group B $450 annually $37.50 monthly	Group B $900.96 annually $75.08 monthly

Note: TRICARE Prime enrollment fees are subject to increase each calendar year. Please check Johns Hopkins USFHP website **hopkinsusfhp.org** for current fees. Should you become Medicare-eligible while enrolled in the Plan, please notify the Enrollment department, and upon verification of Part B coverage, your portion of the enrollment fee will be considered paid in full. This applies to Group A only.

The following information is only applicable to members with an approved exemption and waiver for the requirement to pay enrollment fees by allotment.

Annual/Quarterly Payments:

If you have an approved waiver to pay your enrollment fee on annual/quarterly basis, please remember the following:

- When paying enrollment fees on an annual/quarterly basis, you will receive a bill 30 days prior to your next annual/quarterly payment due date.

  Note: The only acceptable payment is by credit card.
- If you fail to make a timely payment, you will be subject to disenrollment.

Moving with TRICARE Prime

If you are changing TRICARE regions, you can transfer your enrollment online, by mail (enrollment form) or telephone. Your enrollment will be effective the date your request is received or six days from the date the request is submitted online through Beneficiary Web Enrollment (BWE).

Split Enrollment

Members of same family may be enrolled in TRICARE in different regions. Only one region will be for the entire family enrollment. The sponsor's enrollment determines which region receives the payment.

- The region where the sponsor is enrolled is the lead contractor and will bill for the entire family.
- If the sponsor is not enrolled, the region with the oldest enrolled family member is the lead contractor and will bill for the entire family.

College Students

Dependent children attending college in another state (outside The Plan area), should enroll in the region where they attend college and transfer back into Johns Hopkins USFHP during the summer to avoid POS option costs for services obtained outside the service area.

Disenrollment

As a member of Johns Hopkins USFHP, you will automatically stay enrolled unless you elect to disenroll during your annual re-enrollment period.

Important: If your membership with USFHP began on or after October 1, 2012, you will be disenrolled from the plan when you become eligible for Medicare.

If you disenroll or become ineligible for the plan, your coverage ends at midnight on the date you cease to be an eligible beneficiary, including when you move out of the area.

Note: Please be aware that Johns Hopkins USFHP will not be responsible for charges associated with any service that you receive, including prescriptions, effective midnight of the date of your disenrollment. This is also true for retroactive disenrollments.

Automatic Disenrollment

Members may be automatically disenrolled in any of the following situations:

- Nonpayment of enrollment fees

- Loss of eligibility for military health benefits
- Permanent address outside of USFHP service area
- Members who enrolled in the plan on or after October 1, 2012, will be disenrolled when they reach age 65.

Notification of Disenrollment

Upon disenrollment from Johns Hopkins USFHP, you will receive a Disenrollment Letter from us. It is the member's responsibility to notify USFHP within 30 days of receipt of the letter if you feel you were disenrolled in error.

Other Insurance

Reporting Other Health Insurance is a Plan requirement. Please call the Coordination of Benefits department at 410-424-4716 to report any other insurance plans.

Coordination of Benefits

As a DoD-authorized provider of TRICARE coverage, Johns Hopkins USFHP is committed to preventing waste of federal resources. One critical way to do this is by verifying any other health insurance coverage our members have. Johns Hopkins USFHP and all TRICARE plans cannot pay any benefit that is payable by another health plan or health care coverage. Under this law, as well as clear DoD requirements, if you have other health care coverage, that coverage must be billed first, before USFHP is required to provide benefits to you. Please complete the Other Health Insurance (OHI) form on our website at **hopkinsusfhp.org/members/plan-documents**.

Third-Party Liability and Work-Related Injury

If you receive care for injuries from an auto accident or a work-related injury for which a third-party insurer is responsible for payment, you must inform the Coordination of Benefits department by calling 410-424-4716. You should advise the Plan whether or not you intend to seek compensation. Failure to report this could result in loss of coverage for care related to this injury.

Insurance Changes

If you change your insurance coverage, or if you obtain commercial insurance coverage after joining Johns Hopkins USFHP, you must report it by calling the Coordination of Benefits department at 410-424-4716.

Marketing and Enrollment Limitations

Johns Hopkins USFHP does not intentionally market to any beneficiaries with other health insurance (OHI). If a beneficiary has both USFHP and Federal Employee Health Benefits Plan (FEHBP), the beneficiary can either suspend FEHBP or will be treated as a beneficiary with OHI.

Customer Service

If you would like to get information on benefits and services, check on the status of a claim or lodge a complaint with the Complaints and Grievance department, the Customer Service department will assist you.

Contact Us

Telephone:
Monday through Friday (8 a.m. - 4:30 p.m.)
410-424-4528
800-808-7347 (toll free)
Fax: 410-424-4895
Assistance for the hearing impaired: Contact Maryland Relay at 800-201-7165

Write:
Johns Hopkins USFHP
Customer Service Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Email:
usfhpcustomerservice@jhhp.org

Internet / HealthLINK Portal:
hopkinsusfhp.org (link under I'm a Member)

Claims and Member Reimbursements

Members of Johns Hopkins USFHP should never receive a claim or a bill from a participating provider for a covered service except for their applicable co-payments. Participating providers are required to bill the Plan directly for all covered services provided to members. If you should receive a claim or a bill in error, email complaintsandgrievances@jhhp.org or call the USFHP Customer Services department at 410-424-4528 or 800-808-7347 and ask the representative to contact the provider to correct the error.

There is one exception to this policy: If you are traveling outside the service area and require urgent or emergency care, the provider should bill the USFHP at the address shown on the back of your Member ID card. However, some providers (especially if they are outside of the United States) may require immediate payment from you. If so, be sure to obtain a receipt and a copy of the bill and submit them along with a Reimbursement Form to the Plan for reimbursement upon your return

Note: Member Reimbursements and all necessary attachments must be received within 365 days from the Date of Service (DOS) to be considered for payment.

Login to your HealthLINK portal, (or create an account if you don't have one yet), click "Claims Reimbursement Form" under the "My Health Plan" tab, click "Member Reimbursement Form" and fill it out. Be sure to enter in all the required information and attach proof of payment information to ensure timely processing. We have also created a step-by-step guide to help you.

Grievances, Complaints and Appeals

Verbal Complaint Procedure

Johns Hopkins USFHP appreciates member feedback. If you are dissatisfied with personnel, services or quality of care, please call Johns Hopkins USFHP Customer Services, toll-free, at 800-808-7347. All attempts will be made to resolve the complaint to your satisfaction during your initial call to Customer Service. If Customer Service does not resolve your complaint to your satisfaction, please file a formal grievance. Your formal grievance will be forwarded to the Complaints and Grievances Department for additional investigation.

Written Grievance (Complaint) Procedure

If you wish to register a formal grievance in writing, please send to the following address:

Johns Hopkins USFHP
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Attn: Complaints and Grievances

Please include a detailed description in your letter, including dates and names of individuals involved

Grievance (Complaint) Resolution

After receiving your formal grievance, a Complaints and Grievances representative will notify you of its receipt and begin appropriate research.

Information regarding the investigation will not become part of your medical record. However, it is not always possible to remain anonymous throughout the proceedings. If Johns Hopkins USFHP is not able to comply with requests to remain anonymous, this will be explained to you during the investigation and you will have the opportunity to withdraw your grievance.

Your complaint will be resolved within 60 calendar days. If there is no resolution within 30 days, we will provide a written update to advise the case is still being investigated. If your complaint is related to the quality of care rendered by a network provider, the written response will be limited to confirmation that the case was investigated because results of the investigation and associated corrective action steps are confidential and therefore cannot be shared. If you have any questions or concerns during the process, please feel free to discuss with Customer Service or your Complaint and Grievance representative.

Appeals Procedure

You can appeal certain Johns Hopkins USFHP/TRICARE Prime decisions. The following issues are subject to reconsideration (i.e., can be appealed) if you as the beneficiary and/or your provider are dissatisfied with an initial denial:

- Medical necessity and appropriateness of the services furnished or proposed to be furnished
- Appropriateness of the setting in which the services were or are proposed to be furnished
- A determination regarding benefits under this program

If you believe that a claim was improperly denied, in whole or in part, you may file an appeal. Appeals relating to factual determinations involve issues other than medical necessity (e.g., whether a service is covered under TRICARE policy or regulation). Appeals must be filed in writing within 90 calendar days of the date of the initial denial determination. Include patient's name, address, phone number, Johns Hopkins USFHP I.D. number, sponsor's name, and the reason for the appeal and copies of any other documents related to the issue.

Mail appeal to:

Johns Hopkins USFHP
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Attn: Appeals Department

A request for a reconsideration of a concurrent review denial (e.g., you, as the patient, are still in the facility) or a request for an expedited reconsideration of a preadmission/preprocedure denial must be filed within a much shorter time. Contact the Customer Service department at 410-424-4528 or 800-808-7347 for further details relating to the appeal process.

The TRICARE Quality Monitoring Contractor (TQMC) is the final appeals level for medical necessity and appropriateness of care setting.

Customer Service can assist you with the appeal process. Call 410-424-4528 or 800-808-7347.

Members' Rights and Responsibilities

We value you as a member of Johns Hopkins USFHP 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 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 USFHP or our providers treat you.
- File complaints, appeals and grievances with us.

- 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 doctor in USFHP's network if you disagree with your doctor's opinion about the services that you need. Contact us at 800-808-7347 for help searching for another doctor.
- Receive other information about us such as how we are managed. You may request this information by calling 800-808-7347.
- Receive information about the health plan, its services, its practitioners, and providers and member rights and responsibilities.
- 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 USFHP. If you lose your card, you can obtain a new one by calling Customer Service.
- Follow the Plan's referral and prior-authorization guidelines and polices.
- Cancel doctor's appointments if you cannot keep them.
- Pay any applicable co-pay, coinsurance and deductible at the time of service.
- Report any other health insurance coverage to your doctor and to USFHP.
- Report any communicable diseases, family history, problem with substance abuse, and any other information your doctor may need in order to provide adequate care.
- Cooperate with health care providers and follow plans and instructions for care that you have agreed to with your practitioners.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Privacy and Confidentiality

It is the policy of Johns Hopkins USFHP to protect the privacy and security rights of all of its health plan members; to maintain the confidentiality of Health Plan information (oral, written, and electronic); and to comply with all applicable federal and state privacy and security laws and regulations, including those under the Health Insurance Portability and Accountability Act (HIPAA).

Information provided to the Plan is kept confidential and will only be used by the Plan for such purposes as but not limited to:

- Care Coordination
- Claims processing
- Coordination of benefits with other plans
- Subrogation of claims, review of a disputed claim

- Program integrity activities (examples: investigation of fraud, waste, abuse, or privacy theft)
- Quality improvement activities
- Other health care operations and/or payment purposes

To ensure responsible maintenance of your Protected Health Information (PHI), the Plan has implemented internal policies and procedures to address how we further protect, secure and limit use and disclosure of your oral, written, and electronic health Plan information. USFHP verifies the identities of both the member and requestor prior to responding to a request for a member's PHI. Examples of such contact include but are not limited to:

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

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.

The Plan secures and limits access to hardcopy and electronic files. Electronic data is password protected. 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 functions. All workforce members are required to only utilize and/or access the "minimum necessary" information to perform their assigned tasks.

For additional information regarding your privacy rights, please see your notice of privacy practices. If you don't have one you may obtain a copy by calling Customer Service at 800-808-7347 or 410-424-4528. You can also find a copy on our web site at **www.hopkinsusfhp.org/wp-content/uploads/2018/02/privacy-policy.pdf.**

Fraud and Abuse

Johns Hopkins USFHP wants to find and stop health care fraud. Fraud is any dishonest act that results in a benefit to the person doing the act or someone else that he or she is not entitled to. Some examples of health care fraud are:

- Using someone else's USFHP member card issued by the Plan.
- Loaning your USFHP member card to another person so that they can receive health care services.
- Selling prescription medicine or items provided to you under the USFHP.
- Forging or changing prescription forms.
- Receiving bills for equipment or services you never received.

As a member you can help reduce health care fraud by following these simple rules:

- Never loan your USFHP insurance card to anyone.
- Report all suspicions of fraud.
- Report lost or stolen insurance cards to the USFHP Customer Service Department at 800-808-7347 or 410-424-4528.

For additional assistance, members can call 877-WE COMPLY (932-6675) to report fraud, waste, and abuse.

Johns Hopkins USFHP Program and Payment Integrity investigates all charges of actual or suspected health care fraud. Reporting is simple. To contact Johns Hopkins USFHP Program and Payment Integrity:

Call: 410-424-4971
Write: Johns Hopkins Health Plans Program and Payment Integrity
Attn: Fraud, Waste and Abuse
7231 Parkway Dr., Suite 100
Hanover, MD 21026
E-mail: FWA@jhhp.org
Fax: 410-424-2708

Definition of Terms

Attending Physician

The physician who is primarily responsible for your care in an inpatient hospital setting.

Authorized Services

Those services authorized by the Plan to be provided to you, upon recommendation by your primary care manager (PCM).

Catastrophic Cap

An upper limit on out-of-pocket expenses placed on Johns Hopkins USFHP covered prescription and medical bills. Dental charges under United Concordia's Dental Value Network do not count toward these caps.

Contractor(s)

Johns Hopkins USFHP programs or Managed Care Support Contractors.

Co-Payment

The fee you are required by law to pay at the time of service.

Custodial Care

Care provided by the non-medically skilled, mainly to help patients with activities of everyday living.

Defense Enrollment Eligibility Reporting System (DEERS)

The worldwide computerized Military Health System that lists all Uniformed Services beneficiaries. Active-duty members are listed automatically.

Dependent

The spouse, eligible child, adult disabled child, or parents of a military sponsor deemed to be entitled to military benefits as determined by military regulations.

Durable Medical Equipment

Medical equipment such as wheelchairs, hospital beds, oxygen, and respirators. Covered when medically necessary and arranged by the Plan.

Eligible Person

A Military Health System (MHS) beneficiary who remains eligible in DEERS. See DEERS.

Emergency

Sudden and unexpected onset of life-, limb-, or sight-threatening conditions requiring immediate medical attention.

Enrollee

A Uniformed Services beneficiary who voluntarily and affirmatively seeks and is accepted for enrollment in the Plan. Eligibility for enrollment in the Plan is based on eligibility for military health care benefits, as indicated in DEERS.

Enrollment Period

The period of time during which enrollees agree to receive covered services solely under the Plan. In general, each enrollment period is 12 months.

Inpatient

A person treated overnight in a hospital as a registered bed patient incurring a charge for room and board, upon the recommendation of a physician.

Managed Care Support Contractor (MCSC)

The civilian contractor designated by DoD to operate TRICARE in a particular region in partnership with the MTFs. The MCSC for Region 1 North is Humana Military.

Medically Necessary

Services that are (1) provided for the diagnosis or care and treatment of a medical condition as determined by a physician; (2) appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition; and (3) within standards of medical practice recognized within the local medical community.

MHS

Military Health System.

Outpatient Care

Outpatient care includes diagnostic and treatment services, supplies, and medicines provided and used at a hospital or other covered facility under the direction of a physician.

Plan

Johns Hopkins USFHP as presented in this document.

Primary Care Manager (PCM)

Each Johns Hopkins USFHP member has a primary care manager who knows the member's medical history, provides most of the member's health care, writes referrals for and monitors any specialist care or tests that are necessary and helps the member prevent medical problems in the future. USFHP primary care managers specialize in internal medicine, family practice or pediatrics.

Provider

A health care professional, institution, facility or agency licensed by the appropriate authority and operating according to law, including a hospital, physician, doctor of podiatry (D.P.M.), licensed clinical psychologist (Ph.D.), certified nurse practitioner, physicians assistant, certified nurse-midwife, or mental health counselor.

Qualifying Life Event

A status change that includes marriage, divorce, birth or adoption of a child, relocation outside of the service area, or loss of eligibility or losing or gaining Other Health Insurance. A QLE for one member means that all family members may make changes within 90 days of the QLE.

Referral

A formal recommendation from a PCM that directs an enrollee to receive health care services from another specified care provider. Entitlement to such services shall not exceed the limits of the referral and is subject to all terms and conditions of the group contract.

Room and Board

Charges made by a hospital or other covered institution for the cost of a room, general-duty nursing care, and other services routinely provided to all inpatients, not including special care units.

Semi-Private Charge

The charge made by a hospital for a room containing two (2) or more beds, but not including the charge made by the hospital for special care units.

Service Area

Johns Hopkins USFHP service area includes the zip codes in the geographic service area approved by DoD. Moving outside the service area is a valid reason to disenroll from the Plan.

Skilled Nursing Facility (SNF)

An institution that meets all the following requirements: (1) is licensed by the appropriate public authority as a skilled nursing facility, (2) is accredited in whole or in a specific part as a skilled nursing facility for the treatment and care of inpatients, (3) is engaged mainly in providing skilled nursing care under the supervision of a physician in addition to providing room and board, and (4) is a freestanding or a designated unit of another licensed health care facility.

Split Enrollment

Refers to multiple family members enrolled in TRICARE Prime under different Lead Agents/ contractors, including Managed Care Support (MCS) contractors and USFHP designated providers.

TRICARE Prime

This benefit provides the most comprehensive coverage for health care benefits at the lowest cost. Each member has a primary care physician who manages all the individual's health care.

Johns Hopkins USFHP Member Card

The card issued by the Plan, identifying a military beneficiary as a member of Johns Hopkins USFHP. It includes important benefit and compliance information. This card should be kept with you at all times.

Johns Hopkins US Family Health Plan

7231 Parkway Drive, Suite 100

Hanover, MD 21076

www.hopkinsusfhp.org

The information contained in this booklet is subject to certain terms, conditions, and limitations and is not intended as a complete description of Plan benefits.

December 2024