# Medical

<table>
<thead>
<tr>
<th>Medical Plan</th>
<th>CareFirst BlueCross BlueShield</th>
<th>Blue Choice HMO In-Network</th>
<th>Kaiser Permanente HMO In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual deductible</strong></td>
<td>$500 per person $1,500 per family</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>Annual out-of-pocket maximum</strong></td>
<td>$1,500 per person $4,500 per family</td>
<td>$1,500 per person $4,500 per family</td>
<td>$3,500 single $9,400 family</td>
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<tr>
<td><strong>Dependent eligibility</strong></td>
<td>Your spouse or domestic partner (if qualified for coverage under Johns Hopkins University Domestic Partnership Policy) may be covered. Your eligible children up to age 26 (end of calendar year dependent turns 26) regardless of other medical coverage; coverage may continue for children) up to any age if they cannot support themselves because of a mental or physical disability that occurred before they reached the age limit when coverage would normally end.</td>
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**Preventive Care**
- Preventive care including physical exams and well care: 100% covered, no deductible
- Immunizations (adult) and mammograms: 100% covered, no deductible

**Physician Services**
- **Office Visit**
  - 80% after deductible; 100% after deductible if JHU network provider
  - 80% after deductible; 100% after deductible if JHU network provider
  - $15 PCP, $30 Specialist
  - $15 PCP, $30 Specialist

- **Medical and Surgical**
  - 80% after deductible; 100% after deductible if JHU network provider
  - Inpatient 100% covered; Outpatient $15 PCP, $30 Specialist
  - Inpatient 100% covered; Outpatient $15 PCP, $30 Specialist

- **Hospital Services**
  - Hospital copay per inpatient admission (not subject to the deductible, but does count toward the out-of-pocket maximum): $150
  - $100
  - $100
  - Hospital services benefits (inpatient): 80% covered after deductible
  - 100% covered
  - 100% covered
  - Emergency care (sudden and serious and accidental injury): $100 copay (waived if admitted)
  - $50 copay (waived if admitted)
  - $75 copay (waived if admitted)
  - Urgent Care: 100% after $30 copay
  - 100% after $25 copay
  - 100% after $30 copay
  - Outpatient surgery: Facility: 100% covered, no deductible
  - Physician: 80% covered after deductible
  - $60 copay
  - $50 copay

**Mental Health/Substance Abuse**
- Mental Health Inpatient: 80% covered after deductible; subject to inpatient copay
- 80% covered after deductible; 100% covered if JHU network provider
- $100 copay

- Mental Health Outpatient: 80% covered after deductible; 100% covered if JHU network provider
- $15 per visit
- Group Therapy: $7 copay
- Individual Therapy: $15 copay

- Substance Abuse Inpatient: 80% covered after deductible; subject to inpatient copay
- 100% covered
- $100 copay

- Substance Abuse Outpatient: 80% covered after deductible; 100% covered if JHU network provider
- $15 per visit
- Group Therapy: $7 copay
- Individual Therapy: $15 copay

**Reproductive Health**
- Pre- and Post- Natal Care: Benefits are available to the same extent as benefits provided for other illnesses, Preventive prenatal services covered 100%, no deductible.
- $30 specialist copay. Benefits are available to the same extent as benefits provided for other illnesses.
- 100% covered except $10 copay to confirm pregnancy

- Family planning and fertility testing: 80% covered after deductible, subject to review
- $15 PCP
- $30 Specialist
- Family planning: 100% covered
- Fertility testing: 50% covered

- Artificial insemination: An approved plan of treatment is required;
  - 80% covered after deductible
  - Physician: 100% covered after deductible if JHU network provider
  - Limited to 6 attempts per live birth and pre-certification required
  - 50% of allowed benefit charges

  Limited to 6 attempts per live birth and $100,000 lifetime maximum. An approved plan of treatment is required.
  - 50% of allowed benefit charges
### In vitro fertilization

- An approved plan of treatment is required
- 80% covered after deductible; Physician: 100% covered after deductible if JHU network provider
- Limited to 3 attempts per live birth and $100,000 lifetime maximum

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<thead>
<tr>
<th>Benefits Provided</th>
<th>50% of allowed benefit charges</th>
<th>Limited to 3 attempts per live birth and $100,000 lifetime maximum</th>
<th>50% of allowed benefit charges</th>
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### Prescription Drugs

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<tr>
<th>Prescription Drugs</th>
<th>Annual out-of-pocket maximum</th>
<th>Retail (Up to a 30-day supply)</th>
<th>Mail Order (Up to a 90-day supply)</th>
<th>Other Benefits</th>
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<tbody>
<tr>
<td></td>
<td>$2,000 per person</td>
<td>Generic: $10</td>
<td>Generic: $25</td>
<td>Pre-Admission Testing</td>
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<td></td>
<td>$6,000 per family</td>
<td>Formulary Brand: if no generic is available, 20% w/ $30 min and $45 max</td>
<td>Formulary Brand: $75</td>
<td>Specialist Care</td>
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<td></td>
<td></td>
<td>Non-formulary Brand: if no generic or formulary brand available, 25% w/ $60 min and $100 max</td>
<td>Non-formulary Brand: $150</td>
<td>Diagnostic Outpatient</td>
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<td>90 day supply</td>
<td>Second Surgical Opinion</td>
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<td>Durable Medical Equipment</td>
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<td>Therapy Services</td>
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<td>Transplant</td>
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<td>Vision Care</td>
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<td>Hearing Aid/Exam</td>
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<td>Gender Reassignment Treatment</td>
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