mychoices

Compare Your 2020 BU Medical Plans

Medical

	CareFirst BlueCross BlueShield	Blue Choice HMO In-Network	Kaiser Permanente HMO In-Network
Annual deductible	$500 per person $1,500 per family	$0	$0
Annual out-of-pocket maximum	$1,500 per person $4,500 per family	$1,500 per person $4,500 per family	$3,500 single $9,400 family
Dependent eligibility	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 child(ren) 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	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 child(ren) 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	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 child(ren) 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
Preventive Care			
Preventive care including physical exams and well care	100% covered, no deductible	100% covered	100% covered
Immunizations (adult) and mammograms	100% covered, no deductible	100% covered	100% covered
Physician Services			
Office Visit	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	50% of allowed benefit charges Limited to 3 attempts per live birth and $100,000 lifetime maximum	50% of allowed benefit charges Limited to 3 attempts per live birth and $100,000 lifetime maximum
Prescription Drugs			
Annual out-of-pocket maximum	$2,000 per person $6,000 per family	$2,000 per person $6,000 per family	Integrated with Medical
Retail (Up to a 30-day supply)	Generic: $10 Formulary Brand: If no generic is available, 20% w/ $30 min and $45 max Non-formulary Brand: If no generic or formulary brand available, 25% w/ $60 min and $100 max	Generic: $10 Formulary Brand: If no generic is available, 20% w/ $30 min and $45 max Non-formulary Brand: If no generic or formulary brand available, 25% w/ $60 min and $100 max	Kaiser Pharmacy Generic: $7 Brand: $15 Non-formulary brand: $30 Community Pharmacy Generic: $10 Brand: $20 Non-formulary brand: $35 30 day supply
Mail Order (Up to a 90-day supply)	Generic: $25 Formulary Brand: $75 Non-formulary Brand: $150 90 day supply	Generic: $25 Formulary Brand: $75 Non-formulary Brand: $150 90 day supply	Maintenance drug program up to a 90-day supply for two copays Generic: $14 Brand: $30 Non-formulary brand: $60 90 day supply
Other Benefits			
Pre-Admission Testing	100% covered, no deductible	100% covered	100% covered
Specialist Care	80% covered after deductible; 100% covered after deductible if JHU network provider	$30 copay	$30 copay
Diagnostic Outpatient	80% covered after deductible	100% covered	100% covered
Second Surgical Opinion	100% covered, no deductible	$15 PCP / $30 Specialist	$15 copay
Durable Medical Equipment	80% covered after deductible	100% covered	100% covered
Therapy Services	80% covered after deductible	$15 copay per visit, limited to 30 visits per condition for Occupational Therapy, Speech Therapy, and Physical Therapy combined	$30 copay (occupational, physical, speech therapy limited to 30 visits per episode)
Transplant	Same as In-patient: Travel: $150 per day; $10,000 maximum	Same as In-patient: Travel: $150 per day	100% covered
Acupuncture	80% covered after deductible	Not Covered	Not Covered
Chiropractic Care	80% covered after deductible	$15 copay limited to 30 visits per condition	Not Covered
Vision Care	Adult biennial eye exam covered 100% through Wilmer; must call 410-955-5080 to schedule.	$10 copay Limited to 1 vision exam	$10 copay
Hearing Aid/Exam	Hearing Aids for minor children; 100% covered, no deductible. Ancillary services 80% covered after deductible	Hearing Aids for minor children; 100% allowed benefit. Limited to one hearing aid for each hearing impaired ear every 36 months	Not Covered
Gender Reassignment Treatment	Benefits for transgender services will be available to the extent stated in the Description of Covered Services and Exclusions. Benefits are available to the same extent as benefits provided for other inpatient and outpatient services.	Benefits for transgender services will be available to the extent stated in the Description of Covered Services and Exclusions. Benefits are available to the same extent as benefits provided for other inpatient and outpatient services.	Covered at the applicable copay for members 18 or older. Coverage requires a diagnosis of gender dysphoria that determines treatment is medically necessary in accordance with the Johns Hopkins HealthCare Medical Policy.