2021 Faculty and Staff Medical Plan Coverage Comparison Chart

	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network	BlueChoice HMO In-Network
Annual deductible	$500 per person $1,500 per 3 or more persons*	In-Network: $250 per person $750 per 3 or more persons Out-of-Network: $500 per person $1,500 per 3 or more persons	In-Network: $1,750 per person $3,500 per 2 or more persons Out-of-Network: $3,500 per person $7,000 per 2 or more persons **	$0	$0
Annual out-of-pocket maximum	$2,000 per person $6,000 per 3 or more persons	In-Network: $2,000 per person $6,000 per 3 or more persons Out-of-Network: $4,000 per person $12,000 per 3 or more persons	In-Network: $3,500 per person $7,000 per 2 or more persons Out-of-Network: $7,000 per person $14,000 per 2 or more persons	$3,500 per person $9,400 per 3 or more persons	$2,000 per person $6,000 per 3 or more persons
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.				
How deductible works	* CareFirst BCBS PPO: When the type of coverage is family (3 or more persons), the family deductible amount is calculated by combining the amounts contributed by all the family members covered under the plan. Benefits are paid for a family member who reaches the individual deductible amount before the family deductible amount is reached. A family member may not contribute more than the individual deductible amount to the family deductible amount. * * CareFirst HDHP: When the type of coverage is family (2 or more persons), the full family deductible must be satisfied before insurance will start. The deductible may be met by 1 individual or the combined amount contributed by all members on the plan.				

Preventive Care					
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network	BlueChoice HMO In-Network
Preventive care including physical exams and well care	100% Covered, no deductible Out-of-Network: 70% covered, no deductible	In-Network: 100%, no deductible Out-of-Network: 70% covered, no deductible	In-Network: 100%, no deductible Out-of-Network: 60% covered after deductible	100% covered	100% covered
Immunizations (adult) and mammograms	100% Covered, no deductible Out-of-Network: 70% covered, no deductible	In-Network: 100%, no deductible Out-of-Network: 70% covered, no deductible	In-Network: 100% covered, no deductible Out-of-Network: 60% covered after deductible	100% covered	100% covered
Physician Services					
Office Visit	In-Network: 80% covered after deductible; 100% covered after deductible if JHU network provider Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	$20 PCP $35 Specialist	$20 PCP $35 Specialist
Medical and Surgical	In-Network: 80% covered after deductible; 100% covered after deductible if JHU network provider Out-of-Network: 70% covered after deductible	In-Network: 80% after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	Inpatient: 100% covered Outpatient: $20 PCP / $35 Specialist copays	$20 PCP $35 Specialist

Hospital Services					
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network	BlueChoice HMO In-Network
Hospital copay per inpatient admission *(not subject to the deductible, but does count toward the out-of-pocket maximum)	In-Network: $250 copay * Out-of-Network: $250 copay*	In-Network: $250 copay * Out-of-Network: $250 copay *	No Copay	$250 copay	$250 copay
Hospital services benefits (inpatient)	In-Network: 80% covered after deductible and $250 inpatient copay Out-of-Network: 70% covered after deductible and $250 inpatient copay	In-Network: 80% after deductible & $250 inpatient copay Out-of-Network: 70% covered after deductible & $250 inpatient copay	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	100% covered after $250 copay	100% covered after $250 copay
Emergency care (sudden and serious and accidental injury)	In-Network: Facility: $100 copay, waived if admitted Physician: 80% covered after deductible Out-of-Network: Facility: $100 copay, waived if admitted Physician: 80% covered after deductible	In-Network: Facility: $100 copay, waived if admitted Physician: 80% covered after deductible Out-of-Network: Facility: $100 copay, waived if admitted Physician: 80% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 80% covered after deductible	$100 copay; waived if admitted	$100 copay; waived if admitted

Hospital Services					
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network	BlueChoice HMO In-Network
Urgent Care	In-Network: 100% after $50 copay Out-of-Network: 70% after deductible	100% after $50 copay	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	100% after $50 copay	100% after $50 copay
Outpatient surgery	In-Network: Facility: 100% covered, no deductible Physician: 80% covered after deductible 100% covered after deductible if JHU network provider Out-of-Network: Facility: 70% covered after deductible Physician: 70% covered after deductible	In-Network: Facility: 100% covered Physician: 80% covered after deductible Out-of-Network: Facility: 70% covered after deductible Physician: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	$100 copay	$100 copay

Mental Health/Substance Abuse					
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network	BlueChoice HMO In-Network
Mental Health Support	In-Network: 80% covered after deductible and $250 inpatient copay Out-of-Network: 70% covered after deductible & $250 inpatient copay	In-Network: 80% covered after deductible & $250 inpatient copay Out-of-Network: 70% covered after deductible & $250 inpatient copay	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	100% after $250 copay	100% after $250 copay
Mental Health Outpatient	In-Network: 80% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	$20 per individual visit; $10 per group visit	$20 copay
Substance Abuse Inpatient	In-Network: 80% covered after deductible and $250 inpatient copay Out-of-Network: 70% covered after deductible & $250 inpatient copay	In-Network: 80% covered after deductible & $250 inpatient copay Out-of-Network: 70% covered after deductible & $250 inpatient copay	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	100% covered after $250 copay	100% after $250 copay

Mental Health/Substance Abuse					
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network	BlueChoice HMO In-Network
Substance Abuse Outpatient	In-Network: 80% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	$20 per individual visit; $10 per group visit	$20 copay
Reproductive Health					
Pre- and Post- Natal Care	100% covered Out-of-Network: 70% covered after deductible	In-Network: 100% covered for routine Out-of-Network; 70% covered after deductible	In-Network: 100% covered Out-of-Network: 60% covered	100% covered after initial visit $20 PCP / $35 Specialist copays	$20 PCP / $35 Specialist copays
Family planning and fertility testing	In-Network: Covered 80% after deductible Out-of-Network: 70% covered after deductible, pre-certification required	In-Network: 80% covered after deductible, pre-certification required Out-of-Network: 70% covered after deductible, pre-certification required	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	Family planning: 100% covered Fertility testing: 50% covered	Fertility testing paid as other diagnostic services

Reproductive Health					
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network	BlueChoice HMO In-Network
Artificial Insemination	In-Network: 80% covered after deductible Limited to 6 attempts per live birth and $100,000 lifetime maximum*, pre-certification required Out-of-Network: 70% covered after deductible Limited to 6 attempts per live birth and $100,000 lifetime maximum*, pre-certification required * Lifetime maximum applies to AI, IUI, IVF, GIFT, and ZIFT; both medical and Rx accumulate to the maximum	In-Network: 80% covered after deductible Limited to 6 attempts per live birth and $100,000 lifetime maximum*, pre-certification required Out-of-Network: 70% covered after deductible Limited to 6 attempts per live birth and $100,000 lifetime maximum*, pre-certification required * Lifetime maximum applies to AI, IUI, IVF, GIFT, and ZIFT; both medical and Rx accumulate to the maximum	In-Network: 80% covered after deductible Limited to 6 attempts per live birth and $100,000 lifetime maximum*, pre-certification required Out-of-Network: 60% covered after deductible Limited to 6 attempts per live birth and $100,000 lifetime maximum*, pre-certification required * Lifetime maximum applies to AI, IUI, IVF, GIFT, and ZIFT; both medical and Rx accumulate to the maximum	50% of allowed benefit charges	50% covered Limited to 6 approved attempts per live birth and $100,000 lifetime maximum*, pre-certification required * Lifetime maximum applies to AI, IUI, IVF, GIFT, and ZIFT; both medical and Rx accumulate to the maximum

Reproductive Health					
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network	BlueChoice HMO In-Network
In vitro fertilization	In-Network: 80% covered after deductible; Limited to 3 approved attempts per live birth and $100,000 lifetime maximum* Out-of-Network: 70% covered after deductible; Limited to 3 pre-certified attempts per live birth and $100,000 lifetime maximum* * Lifetime maximum applies to AI, IUI, IVF, GIFT, and ZIFT; both medical and Rx accumulate to the maximum	In-Network: 80% after deductible; Limited to 3 pre-certified attempts per live birth and $100,000 lifetime maximum* Out-of-Network: 70% covered after deductible; Limited to 3 pre-certified attempts per live birth and $100,000 lifetime maximum* * Lifetime maximum applies to AI, IUI, IVF, GIFT, and ZIFT; both medical and Rx accumulate to the maximum	In-Network: 80% covered after deductible Limited to 3 pre-certified attempts per live birth and $100,000 lifetime maximum* Out-of-Network 60% covered after deductible Limited to 3 pre-certified attempts per live birth and $100,000 lifetime maximum* * Lifetime maximum applies to AI, IUI, IVF, GIFT, and ZIFT; both medical and Rx accumulate to the maximum	50% covered up to 3 attempts per live birth; $100,000 lifetime maximum	50% after deductible; Limited to 3 approved attempts per live birth and $100,000 lifetime maximum* * Lifetime maximum applies to AI, IUI, IVF, GIFT, and ZIFT; both medical and Rx accumulate to the 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	Integrated with Medical	$2,000 per person $6,000 per family

Prescription Drugs					
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network	BlueChoice HMO In-Network
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	Generic: $10 copay after deductible Formulary Brand: 20% after deductible Non-Formulary Brand: 25% after deductible	Kaiser Pharmacy Generic: $15 Formulary Brand: $25 Non-Formulary Brand: $40 Community Pharmacy Generic: $20 Formulary Brand: $45 Non-Formulary Brand: $60	Generic: $10 Formulary Brand: 20% w/ $30 min and $45 max Non-Formulary Brand: 25% w/ $60 min and $100 max
Mail Order (Up to a 90-day supply)	Generic: $25 Formulary Brand: If no generic is available, 20% w/ $75 min and $112.50 max Non-Formulary Brand: If no generic or formulary brand available, 25% w/ $150 min and $250 max	Generic: $25 Formulary Brand: If no generic is available, 20% w/ $75 min and $112.50 max Non-Formulary Brand: If no generic or formulary brand available, 25% w/ $150 min and $250 max	Generic: $25 copay after deductible Formulary Brand: 20% after deductible Non-Formulary Brand: 25% after deductible	Generic: $30 copay Formulary Brand: $50 copay Non-Formulary Brand: $80 copay	Generic: $25 Formulary Brand: $75 Non-Formulary Brand: $150
Other Benefits					
Pre-Admission Testing	In-Network: 100% covered; No deductible Out-of-Network: 70% covered, no deductible	In-Network: 100%, no deductible Out-of-Network: 70% covered, no deductible	In-Network: 80% covered after deductible Out-of-Network 60% covered after deductible	100% covered	100% covered

Other Benefits					
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO in-Network	BlueChoice HMO In-Network
Specialist Care	In-Network: 80% covered after deductible Out-of-Network 70% covered after deductible	In-Network: 80% after deductible Out-of-Network 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network 60% covered after deductible	$35 copay	$35 copay
Diagnostic Outpatient	In-Network: 80% covered after deductible Out-of-Network 70% covered after deductible	In-Network: 80% after deductible Out-of-Network 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network 60% covered after deductible	100% covered	100% covered
Second Surgical Opinion	In-Network: 100% covered, no deductible Out-of-Network 70% covered after deductible	In-Network: 80% after deductible Out-of-Network 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network 60% covered after deductible	$20 PCP / $35 Specialist	$20 PCP / $35 Specialist
Durable Medical Equipment	In-Network: 80% covered after deductible Out-of-Network 70% covered after deductible	In-Network: 80% after deductible (pre-certification required) Out-of-Network 70% covered after deductible (pre-certification required)	In-Network: 80% covered after deductible Out-of-Network 60% covered after deductible	100% covered	100% covered

Other Benefits					
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO in-Network	BlueChoice HMO In-Network
Therapy Services	In-Network: 80% covered after deductible; covered at 100% after deductible if JHU network provider Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible (physical/occupational therapy limited to combined 45 visits per year); Speech Therapy (non- developmental) 30 visits per year (pre-certification required) Out-of-Network: 70% covered after deductible (physical therapy: 45 visit limit; speech therapy: 30 visit limit)	In-Network: 80% covered after deductible (physical/occupational and speech therapy limited to combined 90 visits per year in- or out-of-network) Out-of-Network 60% covered after deductible (physical/occupational and speech therapy limited to combined 90 visits per year in- or out-of-network)	$35 copay (occupational, physical, speech therapy limited to 30 visits per episode)	$35 copay
Transplant	In-Network: 80% covered after deductible and $250 inpatient copay Out-of-Network 70% covered after deductible and $250 inpatient copay Travel: $150 per day, $10,000 maximum	In-Network: 80% after deductible Out-of-Network 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network 60% covered after deductible Travel: $150 per day, $10,000 maximum	100% covered	Benefits are available to the same extent as benefits provided for other illnesses

Other Benefits					
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO in-Network	BlueChoice HMO In-Network
Acupuncture	In-Network: 80% covered after deductible; covered at 100% after deductible if JHU network provider Out-of-Network 70% covered after deductible	In-Network: 80% after deductible up to $1,000 annual maximum Out-of-Network 70% covered after deductible	In-Network: 80% covered after deductible (limited to 30 visits per year, combined in- and out-of network) Out-of-Network 60% covered after deductible (limited to 30 visits per year, combined in- and out- of network)	Not covered	Not covered
Chiropractic Care	In-Network: 80% covered after deductible; covered at 100% after deductible if JHU network provider Out-of-Network 70% covered after deductible	In-Network: 80% after deductible Out-of-Network 70% covered after deductible	In-Network: 80% covered after deductible (limited to 30 visits per year, combined in- and out-of network) Out-of-Network 60% covered after deductible (limited to 30 visits per year, combined in- and out-of network)	Not covered	$35 copay
Vision Care	Adult biennial eye exam covered 100% through Wilmer; must call 410-955-5080 to schedule	In-Network: One biennial eye exam covered 100% Out-of-Network: Not covered	Not covered	$20 PCP / $35 Specialist	$10 copay

Other Benefits					
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO in-Network	BlueChoice HMO In-Network
Hearing Aid/Exam	Hearing Aids for minor children; Limited to one hearing aid for each hearing impaired ear every 36 months In-network: 100% covered, no deductible Out-of-Network: 70% covered after deductible	Hearing Aids for minor children; 80% covered in-network, after the deductible. 70% covered out-of-network, after the deductible. Maximum benefit $1,400 per aid for each hearing impaired ear every 36 months	Hearing Aids for minor children; 100% covered after deductible. Limited to one hearing aid for each hearing impaired ear every 36 months	Not covered	Hearing Aids for minor children; 100% covered. Limited to one hearing aid for each hearing impaired ear every 36 months
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.	Covered 80% 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.	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 Kaiser Medical Policy.	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.

This medical plan coverage comparison chart provides an overview of the Johns Hopkins University medical plans for faculty and staff. The university has made every effort to ensure that this chart accurately reflects the plan documents and contracts. If there is a discrepancy between this chart and those documents or contracts, the documents, summary plan descriptions, or contracts will take precedence.