Health Plan Comparison Chart

In-network costs shown

Benefits	CareFirst BlueCross BlueShield PPO 1-877-691-5856 carefirst.com	BlueChoice (HMO) 1-877-691-5856 carefirst.com	Kaiser Permanente (HMO) 1-800-777-7902 kaiserpermanente.org
Annual deductible (does not apply to out-of-pocket maximum)	$500 per person $1,500 per 3 or more persons	None	None
Annual out-of-pocket maximum	$1,500 per person $4,500 per 3 or more persons	$1,500 per person $4,500 per 3 or more persons	$3,500 per person $9,400 per 3 or more persons
Annual maximum benefit	None	None	
Preventive Care			
Preventive care Adult physical Well child exam OB-GYN exam	100% covered once per calendar year (well child exams covered through age 17)	100% covered	100% covered
Immunizations (adult) and mammograms	100% covered	100% covered	100% covered
Physician Services			
Physician services (office visit)	80% covered after deductible; 100% covered after deductible if JHU network provider (you will incur additional expenses for diagnostic testing, facility, and hospital charges)	$15 copay; $30 specialist copay	$15 copay; $30 specialist copay
Physician services (medical and surgical)	80% covered after deductible; 100% covered after deductible if JHU network provider (you will incur additional expenses for diagnostic testing, facility, and hospital charges)	Inpatient 100% covered; outpatient $15 PCP copay; $30 specialist copay	Inpatient 100% covered; outpatient $15 copay; $30 specialist copay
Hospital Services			
Hospital service benefits (inpatient)	80% covered after deductible	100% covered	100% covered
Hospital copay per inpatient admission	$150 copay	$100 copay	$100 copay
Emergency care (sudden and serious and accidental injury)	$100 copay (waived if admitted)	$50 copay (waived if admitted)	$50 copay (waived if admitted)
Urgent care	$50 copay	$25 copay	$30 copay
Outpatient surgery	Facility: 100% covered Physician: 80% covered after deductible	$60 copay	$50 copay
Telehealth	CareFirst Video Visits and all other telemedicine visits: 80% covered after deductible	CareFirst Video Visits and all other telemedicine visits: $0 preventive copay; $15 PCP copay; $30 specialist copay	100% covered

Important: You will continue to use your current medical ID cards for 2023. New medical ID cards will be issued only if you enroll for the first time or change coverage..

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Mental Health/Substance Abuse			
Mental health (inpatient)	80% covered after deductible Subject to inpatient copay	100% covered Subject to authorization	$100 per admission copay
Mental health (outpatient)	80% covered after deductible 100% covered after deductible if JHU network provider	$15 per visit	Group therapy: $7 copay Individual therapy: $15 copay
Alcohol and drug addiction (inpatient)	80% covered after deductible Subject to inpatient copay	100% covered	$100 per admission copay
Alcohol and drug addiction (outpatient)	80% covered after deductible 100% covered after deductible if JHU network provider	$15 per visit	Group therapy: $7 copay Individual therapy: $15 copay
Reproductive Health			
Pre- and postnatal care	Benefits are available to the same extent as benefits provided for other illnesses. Preventive prenatal services covered 100%; no deductible.	Benefits available to the same extent as benefits provided for other illnesses/ Preventive prenatal/postnatal services covered 100%.	100% covered
Family planning and fertility testing	80% covered after deductible, subject to review	$15 copay per visit $30 specialist copay per visit	100% covered per family planning visit; testing covered at 50%
Artificial insemination	An approved plan of treatment is required; benefits are limited to 6 attempts per live birth; 80% covered after deductible; physician 100% covered after deductible if JHU network provider. Subject to $100,000 infertility lifetime maximum	An approved plan of treatment is required; benefits are limited to 6 attempts per live birth; 50% of allowable charges covered; subject to $100,000 infertility lifetime maximum	50% of allowable charges
In vitro fertilization	An approved plan of treatment is required; benefits are limited to 3 attempts per live birth; 80% covered after deductible; $100,000 infertility lifetime maximum; physician 100% covered after deductible if JHU network provider	An approved plan of treatment is required; benefits are limited to 3 attempts per live birth; 50% of allowable charges covered; subject to $100,000 infertility lifetime maximum	50% covered up to 3 attempts per live birth; $100,000 lifetime maximum

For prescription drug information, see next page.

This matrix summarizes the features of the medical benefits offered under the various plans. If there are any discrepancies between the content of this matrix and the plan document, the document will govern.

Prescription Drug Benefits

When you enroll for medical coverage, you and your covered family members also receive prescription drug benefits. The cost of your prescription depends on whether:

- You purchase it from a retail pharmacy or through mail order
- Your drug is on the formulary (i.e., approved drug list) or not on the formulary
- Your prescription is a generic drug or a formulary brand-name drug
- You met the annual out-of-pocket maximum. Prescription drug costs will count toward a separate out-of-pocket maximum. Once you reach this maximum, eligible prescriptions are covered 100% through the end of the plan year

Generic drugs are lower-cost medications that are just as effective as brand-name drugs. You may pay more if you purchase a brand-name medicine when a generic-equivalent drug is available. You will pay the generic copay plus the difference in cost between the brand-name and the generic drugs. Please note: Some brand-name drugs will also be subject to prior authorization, step therapy, and/or quantity limitations. Express Scripts or Kaiser Permanente (depending on the medical plan you're enrolled in) will contact you if your prescription meets one of these limitations.

If You Are Covered by CareFirst BlueCross BlueShield or BlueChoice

The university offers prescription drug coverage through Express Scripts. The chart below shows what you pay for both retail and mail order. If you take a maintenance medication (e.g., for high blood pressure or high cholesterol), you might want to consider using the mail order program for cost savings and added convenience.

If You Are Covered by Kaiser Permanente

Your prescriptions will be processed by Kaiser. The chart below shows what you pay when you use a Kaiser pharmacy, preferred community pharmacy, or mail order.

CareFirst BlueCross BlueShield and BlueChoice

	BlueCross BlueShield and BlueChoice
Annual out-of-pocket maximum	$2,000 per person $6,000 for three or persons
Retail (Up to 30-day supply)	
Generic	$10 copay
Formulary* brand	If no generic is available, 20% coinsurance ($30 min/$45 max)
Non-formulary* brand	If no generic or formulary brand is available, 25% coinsurance ($60 min/$100 max)
Mail order (Up to 90-day supply)	
Generic	$25 copay
Formulary* brand	$75 copay
Non-formulary* brand	$150 copay

Kaiser Permanente

	Retail (Kaiser pharmacy) (Up to 30-day supply)	**Retail** (Community pharmacy) (Up to 30-day supply)	**Mail order** (Maintenance drug program up to a 90-day supply for two copays)
Annual out-of-pocket maximum	Integrated with medical		
Generic	$7 copay	$10 copay	$14 copay
Formulary* brand	$15 copay	$20 copay	$30 copay
Non-formulary* brand	$30 copay	$35 copay	$60 copay

**A formulary brand is one that is on the approved drug list, or formulary. A non-formulary brand is one that is not on that list.*