

2023 Faculty and Staff Medical Plan Coverage Comparison Chart

	CareFirst BCBS PPO (national/ international)	MD EHP Classic (Cigna national)	CareFirst HDHP (national)	Kaiser Permanente HMO In-Network (Mid-Atlantic)
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
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
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	<p>* CareFirst BCBS PPO and EHP: 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.</p> <p>* 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</p>			

Preventive Care				
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente 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
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
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
Telemedicine	CareFirst Video Visits: In-Network: 80% covered after deductible; No Out-of-Network: benefits All other telemedicine services: In-Network: 80% covered after deductible Out-of-Network: 70% after deductible	Johns Hopkins OnDemand Virtual Care: In-Network: 80% after deductible; No Out-of-Network: benefits All other telemedicine services: In-Network: 80% covered after deductible Out-of-Network: 70% after deductible	CareFirst Video Visits: In-Network: 80% covered after deductible; No Out-of-Network: benefits All other telemedicine services: In-Network: 80% covered after deductible Out-of-Network: 70% after deductible	100% covered

Physician Services				
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network
Medical and Surgical	<p>In-Network: 80% covered after deductible; 100% covered after deductible if JHU network provider</p> <p>Out-of-Network: 70% covered after deductible</p>	<p>In-Network: 80% after deductible</p> <p>Out-of-Network: 70% covered after deductible</p>	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 60% covered after deductible</p>	<p>Inpatient: 100% covered</p> <p>Outpatient: \$20 PCP / \$35 Specialist copays</p>
Hospital Services				
Hospital copay per inpatient admission *(not subject to the deductible, but does count toward the out-of-pocket maximum)	<p>In-Network: \$250 copay *</p> <p>Out-of-Network: \$250 copay*</p>	<p>In-Network: \$250 copay *</p> <p>Out-of-Network: \$250 copay *</p>	No Copay	\$250 copay
Hospital services benefits (inpatient)	<p>In-Network: 80% covered after deductible and \$250 inpatient copay</p> <p>Out-of-Network: 70% covered after deductible and \$250 inpatient copay</p>	<p>In-Network: 80% after deductible & \$250 inpatient copay</p> <p>Out-of-Network: 70% covered after deductible & \$250 inpatient copay</p>	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 60% covered after deductible</p>	100% covered after \$250 copay

Hospital Services				
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network
Emergency care (sudden and serious and accidental injury)	<p>In-Network: Facility: \$100 copay, waived if admitted Physician: 80% covered after deductible</p> <p>Out-of-Network: Facility: \$100 copay, waived if admitted Physician: 80% covered after deductible</p>	<p>In-Network: Facility: \$100 copay, waived if admitted Physician: 80% covered after deductible</p> <p>Out-of-Network: Facility: \$100 copay, waived if admitted Physician: 80% covered after deductible</p>	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 80% covered after deductible</p>	\$100 copay; waived if admitted
Urgent Care	<p>In-Network: 100% after \$50 copay</p> <p>Out-of-Network: 70% covered after deductible</p>	100% after \$50 copay	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 60% covered after deductible</p>	100% after \$50 copay
Outpatient surgery	<p>In-Network: Facility: 100% covered, no deductible Physician: 80% covered after deductible 100% covered after deductible if JHU network provider</p> <p>Out-of-Network: Facility: 70% covered after deductible Physician: 70% covered after deductible</p>	<p>In-Network: Facility: 100% covered Physician: 80% covered after deductible</p> <p>Out-of-Network: Facility: 70% covered after deductible Physician: 70% covered after deductible</p>	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 60% covered after deductible</p>	\$100 copay

Mental Health/Substance Abuse

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

Reproductive Health

	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network
Pre- and Post- Natal Care	<p>100% covered</p> <p>Out-of-Network: 70% covered after deductible</p>	<p>In-Network: 100% covered for routine</p> <p>Out-of-Network;; 70% covered after deductible</p>	<p>In-Network: 100% covered</p> <p>Out-of-Network: 60% covered</p>	<p>100% covered after initial visit</p> <p>\$20 PCP / \$35 Specialist copays</p>
Family planning and fertility testing	<p>In-Network: Covered 80% after deductible</p> <p>Out-of-Network: 70% covered after deductible, pre-certification required</p>	<p>In-Network: 80% covered after deductible, pre-certification required</p> <p>Out-of-Network: 70% covered after deductible, pre-certification required</p>	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 60% covered after deductible</p>	<p>Family planning: 100% covered</p> <p>Fertility testing: 50% covered</p>
Artificial Insemination	<p>In-Network: 80% covered after deductible Limited to 6 attempts per live birth and \$100,000 lifetime maximum*, pre-certification required</p> <p>Out-of-Network: 70% covered after deductible Limited to 6 attempts per live birth and \$100,000 lifetime maximum*, pre-certification required</p> <p>* Lifetime maximum applies to AI, IUI, IVF, GIFT, and ZIFT; both medical and Rx accumulate to the maximum</p>	<p>In-Network: 80% covered after deductible Limited to 6 attempts per live birth and \$100,000 lifetime maximum*, pre-certification required</p> <p>Out-of-Network: 70% covered after deductible Limited to 6 attempts per live birth and \$100,000 lifetime maximum*, pre-certification required</p> <p>* Lifetime maximum applies to AI, IUI, IVF, GIFT, and ZIFT; both medical and Rx accumulate to the maximum</p>	<p>In-Network: 80% covered after deductible Limited to 6 attempts per live birth and \$100,000 lifetime maximum*, pre-certification required</p> <p>Out-of-Network: 60% covered after deductible Limited to 6 attempts per live birth and \$100,000 lifetime maximum*, pre-certification required</p> <p>* Lifetime maximum applies to AI, IUI, IVF, GIFT, and ZIFT; both medical and Rx accumulate to the maximum</p>	<p>50% of allowed benefit charges</p>

Reproductive Health				
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network
In vitro fertilization	<p>In-Network: 80% covered after deductible; Limited to 3 approved attempts per live birth and \$100,000 lifetime maximum*</p> <p>Out-of-Network: 70% covered after deductible; Limited to 3 pre-certified attempts per live birth and \$100,000 lifetime maximum*</p> <p>* Lifetime maximum applies to AI, IUI, IVF, GIFT, and ZIFT; both medical and Rx accumulate to the maximum</p>	<p>In-Network: 80% after deductible; Limited to 3 pre-certified attempts per live birth and \$100,000 lifetime maximum*</p> <p>Out-of-Network: 70% covered after deductible; Limited to 3 pre-certified attempts per live birth and \$100,000 lifetime maximum*</p> <p>* Lifetime maximum applies to AI, IUI, IVF, GIFT, and ZIFT; both medical and Rx accumulate to the maximum</p>	<p>In-Network: 80% covered after deductible Limited to 3 pre-certified attempts per live birth and \$100,000 lifetime maximum*</p> <p>Out-of-Network: 60% covered after deductible Limited to 3 pre-certified attempts per live birth and \$100,000 lifetime maximum*</p> <p>* Lifetime maximum applies to AI, IUI, IVF, GIFT, and ZIFT; both medical and Rx accumulate to the maximum</p>	50% covered up to 3 attempts per live birth; \$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	Integrated with Medical
Retail (Up to a 30-day supply)	<p>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</p>	<p>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</p>	<p>Generic: \$10 copay after deductible Formulary Brand: 20% after deductible Non-Formulary Brand: 25% after deductible</p>	<p>Kaiser Pharmacy Generic: \$15 Formulary Brand: \$25 Non-Formulary Brand: \$40</p> <p>Community Pharmacy Generic: \$20 Formulary Brand: \$45 Non-Formulary Brand: \$60</p>

Prescription Drugs				
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network
Mail Order (Up to a 90-day supply)	<p>Generic: \$25</p> <p>Formulary Brand: If no generic is available, 20% w/ \$75 min and \$112.50 max</p> <p>Non-Formulary Brand: If no generic or formulary brand available, 25% w/ \$150 min and \$250 max</p>	<p>Generic: \$25</p> <p>Formulary Brand: If no generic is available, 20% w/ \$75 min and \$112.50 max</p> <p>Non-Formulary Brand: If no generic or formulary brand available, 25% w/ \$150 min and \$250 max</p>	<p>Generic: \$25 copay after deductible</p> <p>Formulary Brand: 20% after deductible</p> <p>Non-Formulary Brand: 25% after deductible</p>	<p>Generic: \$30 copay</p> <p>Formulary Brand: \$50 copay</p> <p>Non-Formulary Brand: \$80 copay</p>
Other Benefits				
Pre-Admission Testing	<p>In-Network: 100% covered; No deductible</p> <p>Out-of-Network: 70% covered, no deductible</p>	<p>In-Network: 100%, no deductible</p> <p>Out-of-Network: 70% covered, no deductible</p>	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 60% covered after deductible</p>	100% covered
Specialist Care	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 70% covered after deductible</p>	<p>In-Network: 80% after deductible</p> <p>Out-of-Network: 70% covered after deductible</p>	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 60% covered after deductible</p>	\$35 copay
Diagnostic Outpatient	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 70% covered after deductible</p>	<p>In-Network: 80% after deductible</p> <p>Out-of-Network: 70% covered after deductible</p>	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 60% covered after deductible</p>	100% covered
Second Surgical Opinion	<p>In-Network: 100% covered, no deductible</p> <p>Out-of-Network: 70% covered after deductible</p>	<p>In-Network: 80% after deductible</p> <p>Out-of-Network: 70% covered after deductible</p>	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 60% covered after deductible</p>	\$20 PCP / \$35 Specialist

Other Benefits				
	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network
Durable Medical Equipment	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 70% covered after deductible</p>	<p>In-Network: 80% after deductible (pre-certification required)</p> <p>Out-of-Network: 70% covered after deductible (pre-certification required)</p>	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 60% covered after deductible</p>	100% covered
Therapy Services	<p>In-Network: 80% covered after deductible; covered at 100% after deductible if JHU network provider</p> <p>Out-of-Network: 70% covered after deductible</p>	<p>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)</p> <p>Out-of-Network: 70% covered after deductible (physical therapy: 45 visit limit; speech therapy: 30 visit limit)</p>	<p>In-Network: 80% covered after deductible (physical/occupational and speech therapy limited to combined 90 visits per year in- or Out-of-Network:)</p> <p>Out-of-Network: 60% covered after deductible (physical/occupational and speech therapy limited to combined 90 visits per year in- or Out-of-Network:)</p>	\$35 copay (occupational, physical, speech therapy limited to 30 visits per episode)
Transplant	<p>In-Network: 80% covered after deductible and \$250 inpatient copay</p> <p>Out-of-Network: 70% covered after deductible and \$250 inpatient copay</p> <p>Travel: \$150 per day, \$10,000 maximum</p>	<p>In-Network: 80% after deductible</p> <p>Out-of-Network: 70% covered after deductible</p>	<p>In-Network: 80% covered after deductible</p> <p>Out-of-Network: 60% covered after deductible</p> <p>Travel: \$150 per day, \$10,000 maximum</p>	100% covered
Other Benefits				

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

	CareFirst BCBS PPO	EHP Classic	CareFirst HDHP	Kaiser Permanente HMO In-Network
Hearing Aids	<p>Limited to one hearing aid for each hearing impaired ear every 36 months</p> <p>In-network: 80% covered, after deductible</p> <p>Out-of-Network: 70% covered after deductible</p> <p>Maximum benefit: \$1,000</p> <p>No age restrictions</p>	<p>Limited to one hearing aid per hearing impaired ear every 36 months</p> <p>In-network: 80% covered, after deductible</p> <p>Out-of-Network: 70% covered after deductible</p> <p>Maximum benefit: \$1,000</p> <p>No age restrictions</p>	<p>Limited to one hearing aid for each hearing impaired ear every 36 months</p> <p>In-network: 80% covered, after deductible</p> <p>Out-of-Network: 70% covered after deductible</p> <p>Maximum benefit: \$1,000</p> <p>No age restrictions</p>	<p>Limited to one hearing aid for each hearing impaired ear every 36 months</p> <p>100% covered</p> <p>Restricted to children up until the month in which child turns 19</p>
Gender Affirming Care	<p>Benefits for gender affirming care 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.</p>	<p>Benefits for gender affirming care 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.</p>	<p>Benefits for gender affirming care 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.</p>	<p>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.</p>

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.