

Johns Hopkins University - 2008 Health Plan Comparison Chart

	EHP Classic * 800-261-2393 www.ehp.org		Blue Cross Blue Shield Plan * 866-520-6099 www.carefirst.com	Blue Choice** 866-520-6099 www.carefirst.com	Kaiser Permanente ** (HMO) 800-777-7902 www.kaiserpermanente.org
	Option 1 (In-Network)	Option 2 ⁽⁶⁾ (Out-of-Network)			
Annual deductible (does not apply to out-of-pocket maximum)	None	\$250 per person \$750 per family ⁽²⁾	\$250 per person/\$750 per family	None	None
Annual out-of-pocket maximum	\$1,500 per person \$4,500 per family	\$3,000 per person \$9,000 per family	\$1,500 per person \$4,500 per family (not including deductibles or coinsurance for alcoholism treatment or psychiatric services)	None	None
Annual maximum benefit	Options 1 & 2 combined \$5,000,000 per calendar year	Options 1 & 2 combined \$5,000,000 per calendar year	None	None	None
PREVENTIVE CARE					
Well baby care	Covered at 100% (through age 17)	Covered at 70% (no deductible) (through age 17)	100% covered if JHU network provider, deductible waived; covered at 80%, deductible waived (through age 17)	Routine physicals — \$10 copay per visit	Covered in full
Physical exams (routine adult)	Routine annual physical and OB/GYN exam – covered at 100%	Covered at 70%, after deductible	Routine annual physical and OB/GYN exam – covered at 100%	\$10 PCP copay per visit \$20 specialist copay per visit	Covered in full
Immunizations (adult)	Included in routine office benefit	Covered at 70%, after deductible	Included in routine office benefit	Covered in full (included in routine office benefit)	Covered in full
Mammograms (routine)****	Covered at 100%	Covered at 70%, after deductible	Covered at 100%, after deductible	Covered in full	Covered in full
PHYSICIAN SERVICES					
Physician services (office visit)	Covered at 80%	Covered at 70%, after deductible	80% covered, after \$250 calendar year deductible; 100% covered if JHU network provider after \$250 deductible	\$10 PCP copay per visit \$20 specialist copay per visit	\$10 primary copay per visit \$20 specialist copay per visit
Physician services (medical and surgical)	Covered at 80% (inpatient)	Covered at 70%, after deductible (inpatient)	80% covered, after \$250 calendar year deductible; 100% covered, after deductible if JHU network provider	Inpatient covered in full; outpatient \$10 PCP copay may apply \$20 specialist copay	Inpatient covered in full; outpatient \$10 copay for primary care doctor \$20 copay for specialist
Specialist care (inpatient)	Covered at 80%	Covered at 70%, after deductible	80% covered, after \$250 calendar year deductible; 100% covered, after deductible if JHU network provider	Covered in full	Covered in full
Specialist care (outpatient)	Covered at 80%	Covered at 70%, after deductible	80% covered after \$250 calendar year deductible; 100% covered, after deductible if JHU network provider	\$20 copay per visit	\$20 copay
Second Surgical opinion	Covered at 80%	Covered at 70%, after deductible	No deductible, 100% of allowed benefit	\$10 PCP copay per office visit \$20 specialist copay per visit	Covered in full
Diagnostic services (outpatient)	Covered at 80%	Covered at 70%, after deductible	Covered at 80%, after \$250 calendar year deductible	Covered in full	Covered in full

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HOSPITAL SERVICES					
Hospital copay per inpatient admission (not subject to deductible)	\$250 per inpatient admission including mental health and substance abuse	\$250 per inpatient admission including mental health and substance abuse	\$250 per inpatient admission including mental health and substance abuse	\$250 per inpatient admission including mental health and substance abuse	\$250 per inpatient admission including mental health and substance abuse
Hospital service benefits (inpatient)	Covered at 80% after \$250 hospital copay per inpatient admission	Covered at 70% after \$250 hospital copay per inpatient admission and deductible ⁽¹⁾	80% covered for an unlimited number of days (365) after \$250 hospital copay per inpatient admission	Covered in full (unlimited days) after \$250 hospital copay per inpatient admission	Covered in full (unlimited days) after \$250 hospital copay per inpatient admission
Emergency care	Sudden and serious and accidental injury • Facility: \$75 copay (waived if admitted) • Physician: Covered at 80%	Sudden and serious and accidental injury. • Facility: \$75 copay (waived if admitted) • Physician: Covered at 70%, after deductible	Sudden and serious and accidental injury • Facility: \$75 copay (waived if admitted) • Physician: Covered at 80%, after deductible	\$75 copay per hospital visit in emergency room (waived if admitted)	\$75 copay per hospital visit (waived if admitted)
Outpatient surgery	• Facility: covered in full • Physician: covered at 80%	• Facility: covered at 70%, after deductible • Physician: covered at 70%, after deductible	• Facility: covered in full • Physician: covered at 80%, after \$250 calendar year deductible	\$10 PCP copay per visit \$20 specialist copay per visit	\$10 PCP copay per visit \$20 specialist copay per visit
Ambulance service	Covered at 80%	Covered at 70%, after deductible	Covered at 80%, after \$250 calendar year deductible	Covered in full	Covered in full
MENTAL HEALTH/SUBSTANCE ABUSE					
Mental and nervous (inpatient)	Must be pre-certified — 30 days per calendar year covered at 80%, 31 st day and beyond covered at 60% ⁽²⁾⁽³⁾⁽⁵⁾ ; \$250 inpatient copay	Must be pre-certified — 30 days per calendar year covered at 70%, after deductible, 31 st day and beyond covered at 50% ⁽²⁾⁽³⁾⁽⁵⁾ ; \$250 inpatient copay	30 days per calendar year covered at 80%, after \$250 calendar year deductible; additional days covered at 60%, but not subject to out-of-pocket maximum; \$250 inpatient copay	Covered in full; subject to authorization from Magellan; \$250 inpatient copay	Covered in full; partial hospitalization at \$20 per visit up to 60 days; \$250 inpatient copay
Mental and nervous (outpatient)	Must be pre-certified ** Visits 1-10 — covered at 80% Visits 11-30 — covered at 65% Visits 31-100—covered at 50% ⁽²⁾⁽³⁾⁽⁵⁾	Must be pre-certified ** covered at 50%, after deductible (100 visits per calendar year) ⁽²⁾⁽³⁾⁽⁵⁾	Visits 1-10 — covered at 80% after deductible ⁽²⁾ Visits 11-30 — covered at 65% after deductible ⁽²⁾ Visits 31-100—covered at 50% after deductible ⁽²⁾	Visits 1-5 — 80% of allowed benefit ⁽²⁾ Visits 6-30 — 65% of allowed benefit ⁽²⁾ Visits 31+ — 50% of allowed benefit ⁽²⁾	\$20 Individual visits \$10 Group visits
Alcohol and drug addiction (inpatient)	Must be pre-certified **; \$250 inpatient copay	Must be pre-certified **; \$250 inpatient copay	Alcohol: 30 days per calendar year covered at 80% after \$250 calendar year deductible and \$250 inpatient copay; additional benefit of \$1,000 per calendar year paid at 50%; 120 visits/days lifetime maximum combined inpatient and outpatient Drug Abuse: 21 days per calendar year covered at 80% after \$250 calendar year deductible and \$250 inpatient copay; inpatient withdrawal limited to 7 days per calendar year	Covered in full; partial hospitalization allows up to 60 days per calendar year and applies a \$10 copay per day ⁽³⁾ ; \$250 inpatient copay	Covered in full; partial hospitalization at \$20 per visit for up to 60 days; \$250 inpatient copay

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Alcohol and drug addiction (outpatient)	Must be pre-certified ** (\$5,000 lifetime maximum)	Must be pre-certified ** (\$5,000 lifetime maximum)	Covered at 80%, up to \$1,000 calendar year maximum** (\$5,000 lifetime maximum)	Visits 1-5 — 80% of allowed benefit Visits 6-30 — 65% of allowed benefit Visits 31+ — 50% of allowed benefit (combined with outpatient mental and nervous) ⁽³⁾	\$20 Individual visits \$10 Group visits
OTHER					
Home health care	90 visits per year covered in full ⁽⁵⁾	90 visits per year covered at 70%, after deductible ⁽⁵⁾	90 day per calendar year maximum, covered in full (Agency); physician covered at 80% after deductible	Covered in full	Covered in full
Durable medical equipment (see also prescription drugs)	Covered at 80%	Covered at 70%, after deductible	Covered at 80%, after \$250 calendar year deductible	Covered in full	Covered in full
Reproductive health					
Pre- and post-natal care	Covered at 80%	Covered at 70%, after deductible	Covered at 80% after \$250 calendar year deductible; 100% covered after deductible if JHU Special Physician	\$20 specialist copay (member will not pay more than \$200 per pregnancy)	Covered in full except \$10 copay to confirm pregnancy; \$20 copay for specialist to confirm pregnancy
Family planning & fertility testing	Must be pre-certified ** Family planning not covered; fertility testing covered at 80%	Must be pre-certified ** Family planning not covered; fertility testing covered at 70%, after deductible	Family planning not covered; fertility testing covered 80% after deductible, subject to review	\$10 PCP copay per visit \$20 specialist copay per visit	Covered in full per visit, testing covered at 50%
Artificial insemination****	Covered at 80%, medical criteria must be met, pre-certification required; unlimited attempts ⁽⁷⁾	Covered at 70% of R & C, after deductible; medical criteria must be met, unlimited attempts, pre-certification required for all services ⁽⁷⁾	Covered at 80% after \$250 calendar year deductible	50% of allowed benefit	**
In vitro fertilization****	Covered at 80%, medical criteria must be met; limited to three attempts per live birth, pre-certification required for all services ⁽⁷⁾	Covered at 70% of R & C, after deductible, medical criteria must be met; limited to three attempts per live birth, pre-certification required for all services ⁽⁷⁾	Covered at 80% after \$250 calendar year deductible; \$100,000 lifetime maximum or 3 attempts per live birth	50% of allowed benefit; \$100,000 lifetime max. or 3 attempts per live birth	Covered up to 3 attempts per live birth to a limit of \$100,000 lifetime benefit covered at 50%
Hearing Exams	Not covered	Not covered	Not covered	\$10 PCP copay per visit \$20 specialist copay per visit (no age limit)	\$20 copay as part of a health assessment Hearing aid coverage (children only)**
Vision care	Covered in full, one exam every two years (JH routine vision care network)	Not covered	Adult biennial eye exams covered in full*** (call 410-614-TEST to schedule); if medical, subject to deductible and coinsurance	Annual eye exam: \$10 copay optometrist \$25 ophthalmologist	\$10 copay optometrist, \$20 copay ophthalmologist; discounted lenses, frames and contacts

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Prescription drugs	<i>Administered by Medco Health Solutions</i> Retail (30-day supply): \$10 generic \$20 formulary brand \$35 non-formulary brand Mail-order program (90-day supply) for maintenance drugs**: \$20 generic \$40 formulary brand \$70 non-formulary brand	<i>Administered by Medco Health Solutions</i> Retail (30-day supply): \$10 generic \$20 formulary brand \$35 non-formulary brand Mail-order program (90-day supply) for maintenance drugs**: \$20 generic \$40 formulary brand \$70 non-formulary brand	<i>Administered by Medco Health Solutions</i> Retail (30-day supply): \$10 generic \$20 formulary brand \$35 non-formulary brand Mail-order program (90-day supply) for maintenance drugs**: \$20 generic \$40 formulary brand \$70 non-formulary brand	<i>Administered by Medco Health Solutions</i> Retail (30-day supply): \$10 generic \$20 formulary brand \$35 non-formulary brand Mail-order program (90-day supply) for maintenance drugs**: \$20 generic \$40 formulary brand \$70 non-formulary brand	Using a Kaiser facility (30-day supply): \$10 generic \$20 formulary brand \$35 non-formulary brand Using a preferred community pharmacy: \$20 generic \$40 formulary brand \$55 non-formulary brand Maintenance drug mail order program available**
DEPENDENT ELIGIBILITY					
Dependent eligibility	<ul style="list-style-type: none"> • Legally married spouse or same-sex domestic partner (if qualified for coverage under Johns Hopkins University Same-Sex Domestic Partnership Benefits Policy) may be covered • Unmarried dependent child(ren) may be covered up until their 25th birthday; coverage may continue for unmarried dependent 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 				

- (1) Penalty applies for failure to obtain pre-certification for these services.
- (2) Co-insurance does not apply towards out-of-pocket maximum.
- (3) Pre-certification required for all Mental Health and Substance Abuse services — benefits are not paid if services are not pre-authorized.
- (4) Through in-network pharmacies only.
- (5) Visit limits are combined under all options.
- (6) A single deductible applies to services received under Option 2.
- (7) Combined lifetime maximum if \$100,000 for Artificial Insemination and In Vitro Fertilization.

- * Subject to usual, customary, and reasonable limits.
- ** See benefit guides for plan details, exceptions, and restrictions.
- *** Provided through special JHU program only if appointments are scheduled by calling 410-614-TEST.
- **** Subject to age requirements.
- ***** Requires authorization by the plan.

This matrix only 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 documents or vendor contracts, the Plan documents and vendor contracts will govern.